



Annotated Bibliography – Abortion Research in Uganda

13 December 2008

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1. Agyei W and Epema E, Sexual behavior and contraceptive use among 15-24-year-olds in Uganda, *International Family Planning Perspectives*, 1992, 18(1):13-17.

2. Agyei W, Mukiza-Gapere J and Epema E, Sexual behaviour, reproductive health and contraceptive use among adolescents and young adults in Mbale District, Uganda, *Journal of Tropical Medicine and Hygiene*, 1994, 97(4):219-27.

- In this study based on the 1988-1989 DHS survey, almost 75% of 17-year-olds, male or female, were found to have had sex, with little variation between rural and urban residence. By age 19, 77% of rural females had been pregnant, but only 54% of 19-year-old females in Kampala and 30% in other urban centers had experienced a pregnancy. Only about one-third of Kampala sexually active female adolescents not wanting a child were using contraceptives, in rural areas the proportion fell to only 5-6%—lack of access, health fears and ignorance being the main reasons for non-use.
- This study used the sampling frame of 1988-89 DHS. Stratified probability sampling was employed: 2,965 females, 1,545 males 15-24, rural and urban.
- Abstract: Based on the findings of the Ugandan Adolescent Fertility Survey, sexual behavior and contraceptive use among young adults aged 15-24 in both rural and urban Uganda were examined. The survey consisted of 2 phases which took place on August through October 1988 and August and September 1989. The data from 4510 eligible respondents were analyzed. A description of the social and demographic characteristics of the respondents is provided. As the survey data reveal, sexual activity begins at an early age in Uganda. At the time of the survey, 85% of the male sample and 81% of the female sample were sexually experienced. The mean age at first coitus was 15.1 among sexually experienced males and 15.5 among sexually experienced females. The survey also found that nearly 1/2 of all female respondents had ever been pregnant (11% were pregnant at the time of the survey). While 34% of women in small urban centers reported ever being pregnant, the ratio was 61% for rural young women. Of the women who had ever been pregnant, 14% reported having an abortion. Since Uganda allows abortion only for medical reasons, it is suggested that in reality abortion is far more common. Awareness of contraceptive methods was over 80% for both males and females, but fewer than 25% of the sexually active respondents who desired no children actually used contraception. Contraceptive prevalence was significantly lower in rural areas. lack of access to contraception led the reasons for nonuse of contraception, followed by safety concerns and lack of knowledge. These findings suggest the need to make contraceptive service delivery available to adolescents in all parts of the country. [from POPLINE]

3. Ahmed FH et al., Reducing unintended pregnancy and unsafe abortion in Uganda, *Research in Brief*, New York: The Alan Guttmacher Institute, 2005, No. 1.

- This is a report in the Research in Brief series. It presents a summary of research in the indicated areas.

4. Atuyambe L, Mirembe F, Johansson A, Kirumira EK and Faxelid E, Experiences of pregnant adolescents -- voices from Wakiso district, Uganda, *African Health Sciences*, 2005, 5(4): 304-309.

- From this qualitative study in 2002 of adolescents and key informants in Wakiso district: "Discussions revealed that pregnant adolescents faced domestic physical violence. Furthermore, they were psychologically violated by parents and partners, and the community within which they lived. Pregnant adolescents were treated inhumanely and overworked with household chores and had inadequate food to eat. Adolescents experienced stigma and as a result some had carried out unsafe abortions. Key informant interviews and FGDs revealed that health workers were rude and unsympathetic to pregnant adolescents. This significantly contributed to delayed health care seeking when adolescents were ill."
- This is a descriptive study of pregnant adolescents, adolescent mothers, in-charges of health units, opinion leaders and TBAs. It consisted of six focus-group discussions of adolescents and six key-informant interviews.

5. Bazira ER, Induced abortion at Mulago Hospital Kampala, 1983 - 1987: a case for contraception and abortion laws' reform, *Tropical Health*, 1992, 11(1):13-6.

- This is a study of PAC women admitted to Mulago hospital, 1983-1987. Of 1180, 25.4% had induced abortions. There were 33 deaths per 1000 induced abortions. The induced-abortion patients were: 68% aged 15-19, 79% never married, 54% secondary educated, another 24% with some university education, 57% first pregnancy. Induced (25%), probably induced (41%) and spontaneous (34%).
- This study of PAC women recorded 33 deaths per 1000 induced abortions.
- Abstract: In Uganda, university students interviewed 1180 abortion cases admitted to the gynecological emergency ward at New Mulago Hospital in Kampala during 1983-1987 to examine the magnitude of induced abortion at this referral/teaching hospital. Obvious induced abortions, probable induced abortions, and spontaneous abortions comprised 25.4% (300), 40.7% (480), and 33.9% (400), respectively. Further analysis was only conducted on the 300 induced abortion cases. All but 4% (12) of induced abortion cases were younger than 25. Adolescents comprised 67.7% of all induced abortion cases. No one over 34 had an induced abortion. Most induced abortion cases (79%) had never been married. Induced abortion was most common among students (49.7%) and single working women (30.3%) and least common among full-time housewives (5.7%). Induced abortion had a positive association with education (no schooling = 1.3%, primary = 2%, secondary = 53.7%, and university = 23.7%). Christians were more likely to undergo induced abortion than Moslems (43.3% for Protestants and 46.3% for Catholics vs. 10.3% for Moslems). Most of the induced abortion cases had been pregnant with their first pregnancy (57.3%). The main method of pregnancy termination was dilatation and curettage (53.3%). Physicians (91%) performed most of the induced, albeit illegal,

abortions. 56.6% of induced abortion patients stayed in the hospital for no more than 13 days. Patients who stayed for more than two days had serious complications, including hemorrhage (39.7%), sepsis (21%), and genital perforation (15.3%). The main reasons the women sought an induced abortion were desire for more education (48.7%) and fear of parents (25.7%). The induced abortion related mortality rate was 3.3%. These induced abortion cases were probably faced with an unwanted pregnancy. Most knew about family planning, but had not used any of family planning methods. Liberalization of contraception and reform of the abortion law should occur to provide women family planning and legal, inexpensive, and safe abortion services. [from POPLINE]

6. Benson J, Nicholson LA, Gaffikin L and Kinoti SN, Complications of unsafe abortion in Sub-Saharan Africa: a review, *Health Policy and Planning*, 1996, 11(2):117-31.

- **Abstract:** The Commonwealth Regional Health Community Secretariat undertook a study in 1994 to document the magnitude of abortion complications in Commonwealth member countries. The results of the literature review component of that study, and research gaps identified as a result of the review, are presented in this article. The literature review findings indicate a significant public health problem in the region, as measured by a high proportion of incomplete abortion patients among all hospital gynecology admissions. The most common complications of unsafe abortion seen at health facilities were hemorrhage and sepsis. Studies on the use of manual vacuum aspiration for treating abortion complications found shorter lengths of hospital stay (and thus, lower resource costs) and a reduced need for a repeat evacuation. Very few articles focused exclusively on the cost of treating abortion complications, but authors agreed that it consumes a disproportionate amount of hospital resources. Studies on the role of men in supporting a woman's decision to abort or use contraception were similarly lacking. Articles on contraceptive behavior and abortion reported that almost all patients suffering from abortion complications had not used an effective, or any, method of contraception prior to becoming pregnant, especially among the adolescent population; studies on post-abortion contraception are virtually nonexistent. Almost all articles on the legal aspect of abortion recommended law reform to reflect a public health, rather than a criminal, orientation. Research needs that were identified include: community-based epidemiological studies; operations research on decentralization of post-abortion care and integration of treatment with post-abortion family planning services; studies on system-wide resource use for treatment of incomplete abortion; qualitative research on the role of males in the decision to terminate pregnancy and use contraception; clinical studies on pain control medications and procedures; and case studies on the provision of safe abortion services where legally allowed. [from POPLINE]

7. Byamugisha JK, Mirembe FM, Faxelid E, Gemzell-Danielsson K, Emergency contraception and fertility awareness among university students in Kampala, Uganda, *African Health Sciences*, 2006, 6(4):194-200.

- This random survey of female first-year university students at Makerere University in 2005 showed that knowledge of emergency contraception was low: only 45% had heard of the “morning after” pill and almost none knew the pill’s effective time period for use after intercourse (120 hours).

- It was a semi-random survey of first-year female students at Makerere University in 2005. 379 students were selected for self-administered questionnaire. Of 5971 students, sampling continued until 379 questionnaires were completed.

8. Croce-Galis M, Adolescents in Uganda: sexual and reproductive health, *Research in Brief*, New York: Guttmacher Institute, 2005.

- A high proportion of induced abortions occur to adolescents, although hard data are lacking.

9. Gorrette N, Nabukera S and Salihu HM, The abortion paradox in Uganda: fertility regulator or cause of maternal mortality, *Journal of Obstetrics and Gynecology*, 2005, 25(8): 776-780.

- The following is a direct quote from this review article (the first author being a professor in the faculty of medicine at Makerere University) on abortion in Uganda: “The strong desire among couples to limit family size coupled with the lack of access to modern methods of contraception by many women, especially in the rural areas of the country, have contributed to the increasing use of abortion as a means of averting unplanned or mistimed motherhood.”

10. Harper CC, Blanchard K, Grossman D, Henderson JT and Darney PD, Reducing maternal mortality due to elective abortion: potential impact of misoprostol in low-resource settings, *International Journal of Gynecology & Obstetrics*, 2007, 98(1):66-69.

- Abstract. Maternal deaths due to abortion are preventable. Increasing the use of misoprostol for elective abortion could have a notable impact on maternal mortality due to abortion. As a test of this hypothesis, this study estimated the reduction in maternal deaths due to abortion in Africa, Asia and Latin America. The estimates were adjusted to changes in assumptions, yielding different possible scenarios of low and high estimates. This simple modeling exercise demonstrated that increased use of misoprostol, an option for pregnancy termination already available to many women in developing countries, could significantly reduce mortality due to abortion. Empirical testing of the hypothesis with data collected from developing countries could help to inform and improve the use of misoprostol in those settings.

11. Jagwe-Wadda G et al., Abortion morbidity in Uganda: evidence from two communities, *Occasional Report*, New York: Guttmacher Institute, 2006, No. 26.

- Responses from this 2003 qualitative study indicate that ignorance of contraceptive-use directions, and misconceptions about the efficacy of contraceptive methods, are among the reasons leading to contraceptive failure. Male deceit, male opposition and unwanted sex were also cited as reasons for unwanted pregnancies.
- This qualitative study identified some factors that explain why many Ugandan women with serious complications do not seek or receive treatment: the inability to pay for care, fear of revealing that they have had an abortion and concern that they will receive hostile or judgmental treatment from clinic and hospital staff.
- The study design was a random selection of two sub-districts within Kampala (urban) and Mbarara (rural); eight focus group discussions by age group and location; 115 in-depth interviews chosen by location, age group and sex.

12. Johnston HB, Gallo MF and Benson J, Reducing the costs to health systems of unsafe abortion: a comparison of four strategies, *Journal of Family Planning and Reproductive Health Care*, 2007, 33(4):250-7.

- The study uses an accounting model called ‘Savings’, which is a spreadsheet-based tool that allows for the comparison different strategies of providing abortion and post-abortion care. By applying cost data primarily from Uganda, the per-case costs under four policy and service delivery scenarios are shown. The mean per-case cost of abortion care (in US dollars) was \$45 within the setting that placed heavy restrictions on elective abortion and used a conventional approach to service delivery; \$25 within the restrictive legal setting that used recommended interventions for treating complications; \$34 within the legal setting that allowed elective abortion and relied on a conventional approach to service delivery; and \$6 within the liberal legal setting that used recommended interventions.

13. Kampikaho A and Irwig LM, Risk factors for maternal mortality in five Kampala hospitals, 1980-1986, *International Journal of Epidemiology*, 1990, 19(4):1116-8.

14. Kampikaho A and Irwig LM, Incidence and causes of maternal mortality in five Kampala hospitals, 1980-1986, *East African Medical Journal*, 1991, 68(8):624-31.

- This older study looked at all five Kampala hospitals that performed deliveries during the period 1980-1986. The study reported a “non-abortion maternal mortality rate of 2.65 per 1000 deliveries and an abortion-related rate of 3.58 per 1000 abortions.” (Kampikaho 1990) 20% of maternal deaths were abortion related. The rate of abortion-related maternal mortality increased significantly over the 7-year period. (Kampikaho 1991)
- This was a case-control study from 1980 through 1986 of all maternal deaths in all five delivering hospitals in Kampala. One random control was chosen (a woman who delivered and was admitted afterwards) for each maternal death. There were 580 maternal deaths, 372 with case notes recovered. Excluded cases: (1) under 28 weeks gestation, (2) death occurred before delivery and (3) delivered before reaching hospital.
- The study reported 2.65 maternal deaths per 1000 deliveries; 3.58 deaths per 1000 abortions; 20% of maternal deaths were abortion related. The rate of abortion-related maternal mortality increased significantly over the 7-year period. Of 46 abortion-related deaths, 33 caused by sepsis, 6 by hemorrhage, 6 by anesthesia (!), and 1 by “ruptured ectopic”.
- Abstract: Researchers matched each 444 maternal death cases from 4 private hospitals and 1 government national referral hospital in Kampala, Uganda with women who survived pregnancy and delivered in the same ward from 1980-1986 to identify risk factors for maternal mortality. The non-abortion maternal mortality rate for Kampala for this time period stood at 2.65/1000 deliveries. The abortion related mortality rate was 3.58/1000 abortions. The multiple conditional regression model revealed that the highest risk factor for maternal mortality was an Apgar score of 0 (odds ratio=304.31). The poor condition of the mother upon admission posed the 2nd highest risk (OR=100.18). The 3rd highest risk included caesarean or laparotomy (OR=21.46). Apgar scores between 1-6 posed the 4th highest risk (OR=19.91). Further, as the distance from where the mother lived to the hospital increased so did the risk of maternal mortality (p=.0001). Moreover, the more often a mother attended an antenatal clinic the less likely she would die (p=.02). In addition, a significant positive association existed between blood loss and maternal

mortality ($p=.0001$). Physician assisted deliveries presented >15 times the risk of maternal mortality than midwife assisted deliveries. The researchers recommended that governmental vehicles (e.g., military and police) transport pregnant women to a hospital in cases of emergency. They also suggested staff meetings to review maternal deaths and to identify preventive steps, oral and media campaigns about pregnancy related dangers, and training of traditional birth attendants in septic delivery methods and identifying risk factors. [from POPLINE]

- **Abstract:** Maternal mortality is examined from June 1980 to December 1986 at Mulago, Nsambyo, Old Kampala, Rubaga, and Mengo Hospitals in Kampala, Uganda. Clinical or immediate causes, direct and indirect, were recorded from case summary forms based on ICD9 definitions of obstetric complications. The nonabortion maternal mortality rate (NAMMR) was 2.65/1000 deliveries (580 deaths); the abortion-related maternal mortality rate (ARMMR) was 3.58/1000 abortions. The hospital maternal mortality rate was 2.0/1000 deliveries. 75% of maternal deaths of women of 28 weeks' gestation or more had delivered outside the hospital. NAMMR doubled between 1980 and 1986, a statistically significant increase. ARMMR increases were almost significant. 75% were direct obstetric and 21% were indirect obstetric causes. 38% had clinical anemia, 29% had some sepsis, 18% had substantial bleeding, and 14% had obstructed labor. Other contributing conditions were pneumonia, ruptured uterus, laparotomy, evacuations and curettage, malaria, preeclampsia, sickle cell anemia, pulmonary embolism, malnutrition, tetanus, meningitis, prolonged labor, and hepatitis. At admission, 48% were in poor condition, 30% in good condition, and 22% in fair condition. 27% had sickle cell anemia, high blood pressure, multiple pregnancy, or malaria at admission. 64% were admitted within 24 hours after delivery, 67% 1-7 days after delivery, and 92% 7-42 days after delivery. Those in good condition were all admitted <7 days post-delivery. 41% of deaths were due to lack of drugs, 7% lack of fluids, 20% with theater problems, 14% with doctor-related factors, and 3% with midwife-related factors. Better information is needed on mortality before delivery, mortality in hospitals vs. outside, and mortality from abortion, and ectopic and hydatidiform molar pregnancies. An explanation given for the increase in maternal mortality is the decline in economic conditions. Abortion complications may be due to the concealment practiced. Causes are consistent with trends from the 1950s, 1960s, and 1970s in Uganda and developing countries in general. Availability and accessibility of gynecological and obstetric services needs great improvement. Training traditional birth attendants and obtaining rural ambulance services are also needed. Health workers lack creativity and imagination for developing country conditions; scarce resources are not the only problem. [from POPLINE]

15. Kasolo J, Abortion in Uganda, *Initiatives in Reproductive Health Policy*, 2000, 3(2): 9-10.

- This commentary observed that woman's worth and prestige are measured by her ability to feed the family; her health is not a priority. The use of family planning services is discouraged. Because of their low status and barriers to contraception, many unwanted pregnancies and unsafe abortions result. Unless the Ugandan society experiences a shift in attitudes, women's reproductive rights cannot be realized.
- **Abstract:** In Uganda, health care for women is not considered a basic right by society or by women themselves. A woman's worth and prestige are measured by her ability to feed the family; her health is not a priority. They are not allowed to use contraception or any

family planning services. Because of their low status and barriers to contraception, many resulted in unwanted pregnancies and unsafe abortion. It is noted that women seek abortion for various reasons, primarily to continue their education, to maintain a job if the man has denied responsibility, or to avoid producing a child outside wedlock or before marriage. The negative societal attitudes about abortion often result in clandestine abortion. It is evident that unsafe abortion causes 20% of maternal deaths. Unless the Ugandan society experiences a shift in attitudes, women's reproductive rights can never be realized. It is suggested that advocacy, greater acceptance of single motherhood, accessible family planning services, and reproductive health policies can decrease the demand for abortion. [from POPLINE]

16. Kaye DK, Community perceptions and experiences of domestic violence and induced abortion in Wakiso district, Uganda, *Qualitative Health Research*, 2006, 16 (8):1120-1128.

- This study of women seeking PAC in 2003-2004 found a significant link between domestic violence and induced abortion. Beyond the legal situation in Uganda socially sanctioned violence is often associated with unwanted pregnancies and hence with abortion in Uganda.

17. Kaye DK, Mirembe FM, Bantebya G, Johansson A and Ekstrom AM, Domestic violence as risk factor for unwanted pregnancy and induced abortion in Mulago Hospital, Kampala, Uganda, *Tropical Medicine and International Health*, 2006, 11(1):90-101.

- The study of 942 PAC women at Mulago Hospital was carried out in 2003-2004 (333 induced, 609 spontaneous). Being single, in a polygamous relationship and of low parity were related to induced abortion. They were 13 times more likely to have a recent history of domestic violence. Men influence the decision-making process and may force women to consider or procure abortion. Men are also often the source of information about reproductive health and the financial source for abortion or contraception.
- A case-control study at Mulago Hospital (2003-2004) of 942 women seeking post-abortion care. The study identified spontaneous abortions and induced abortions and used the former as a control group.

18. Kaye DK, Mirembe F, Bantebya G, Johansson A and Ekstrom AM, Reasons, methods used and decision-making for pregnancy termination among adolescents and older women in Mulago Hospital, Uganda, *East African Medical Journal*, 2005, 82(11):579-585.

- A study of 942 PAC women at Mulago Hospital was carried out in 2003-2004. Being single, in a polygamous relationship and of low parity were characteristic of patients who had induced abortions. Such women were 13 times more likely to have had a recent history of domestic violence.
- Men influence the decision-making process and may force women to consider or procure abortion. Men are also often the source of information about reproductive health and the financial source for abortion or contraception.

19. Kimanje P, Abortion laws and the rights of the unborn child in Uganda today: the law of abortion in Uganda, 1990, unpublished. [from POPLINE]

- Abstract: Under Ugandan law, induced abortion is legal only to save the life of the mother. Otherwise, a crime has been committed whenever a person through any means

whatsoever knowingly provides a woman with the means to terminate her pregnancy. A woman cannot, however, be convicted of administering poison or noxious substances to herself with the intent to induce her own miscarriage, unless she is with child. Even if the woman is not pregnant, she may be convicted to conspiracy to procure abortion. The intent to induce miscarriage is an essential element of the offence. This paper presents the historical origins of abortion law in Uganda, outlines and discusses current abortion law, and reviews the interest groups involved in the abortion controversy and the development of the laws of abortion in other jurisdictions. The author recommends that Uganda expand the conditions under which legal abortion may be performed.

20. Kinoti SN, Graffikin L, Benson J and Nicholson LA, *Monograph on complications of unsafe abortion in Africa, Arusha, Tanzania: Commonwealth Regional Health Community Secretariat, 1995.*

21. Kinoti SN, Gaffikin L and Benson J, *How research can affect policy and programme advocacy: example from a three-country study on abortion complications in Sub-Saharan Africa, East African Medical Journal, 2004, 81(2):63-70.*

- From a 1993 study of 17 providers and 77 patients in four major hospitals, nurses were more knowledgeable than doctors about on the ground reality about abortion procurement, but in both groups there was a considerable lack of knowledge about the circumstances under which legal abortions were allowed. Despite this lack of knowledge, 80% providers saw existing laws as too restrictive.
- Data collected from four hospitals (one was a rural hospital), no date for study, over a 4-11 month period. In all, the records 946 incomplete abortions were reviewed. Facility abortion case fatality rate was 1.3%. Expert opinion on complication pattern among incomplete abortion cases: hemorrhage 100%; localized infection 82%; septicemia 41%; uterine perforation 35%; cervical injury 24%.
- Abstract: This monograph is based on a 1994 study conducted by the Commonwealth Regional Health Community Secretariat in Maseru, Lesotho, to document the extent of the public health problem posed by abortion in the region and to promote dialogue among health policy makers. Published and unpublished literature (1980-94) was reviewed, and primary data were collected from hospitals in Zambia, Uganda, and Malawi. The monograph opens with 1) an introduction which describes the situation and study background, 2) details of the study methodology, and 3) a review of the literature in which the 99 published and 195 unpublished articles are organized into the following topics: the magnitude of unsafe abortion, maternal mortality statistics, clinical studies, cost studies, the male perspective, contraception and abortion, and abortion law. Country synopses for the primary research done in Zambia, Uganda, and Malawi describe the data collection and major findings for each country. Overall conclusions are that 1) unsafe abortion is an enormous public health problem; 2) the morbidity and mortality associated with it affect women in the prime of their lives; 3) treatment of unsafe abortion demands large amounts of money and resources; 4) safe and effective treatment is usually offered only at large urban hospitals; 5) post-abortion counseling and services are rare; 6) patients seeking treatment for abortion suffer long waits and overcrowded conditions and receive little information; and 7) restrictive laws lead to the proliferation of unsafe abortion. The policy implications of these findings concern improvements in the quality,

accessibility, and availability of post-abortion services and care as well as improvements in the legal environment. Recommended research topics include 1) operations research on improving quality and accessibility of care; 2) documentation of lost work-years and income due to abortion morbidity and mortality; 3) the social context relative to abortion and role of males in the abortion decision; 4) clinical studies on pain control, treatment regimens, and post-abortion care; and 5) case studies describing experiences with safe legal abortions in other countries. [from POPLINE]

22. Kirumira E, Katahoire A, Aboda A and Edstrom K, Study on sexual and reproductive health in Ugandan women, 1993, unpublished. [from POPLINE]

- **Abstract:** A study was undertaken to focus attention on the health and social problems of women in Uganda as they relate to their sexual and reproductive roles. It is hoped that the recommendations arising from this review will provide a basis for the development of a national strategy for women's health and guide both the government and the private sector in attempts to improve conditions for Ugandan women. The data on which this study was based were collected through a review of the literature and of unpublished reports and through a series of open-ended interviews with key informants at the district, health facility, and community levels. The first chapter of the report is devoted to an examination of cultural factors which affect women's health, including customs such as the bride price, polygamy, bride wealth, sexuality, marital instability, sex education, infertility, female genital mutilation, attitudes, and the problems of adolescents; social factors such as education and literacy, women's workload and basic needs, and the participation of women in political activities and women's organizations; and economic factors such as access to income, access to credit, and use of income. The current status of women's health is considered in Chapter 2 in terms of 1) morbidity and health problems (gynecological conditions, sexually transmitted diseases, HIV/AIDS, the problems of illegal abortion [which is widespread and contributes greatly to the maternal death rate, especially among women under 20 years old], and infertility), 2) pregnancy and delivery problems, 3) nutrition, 4) family planning, 5) aging, 6) mortality, and 7) quality of life. Chapter 3 reports on existing health services for women with information on 1) facilities in place, 2) types of health services available, 3) nature of service provision, 4) quality of services, 5) accessibility and cost, 6) acceptability and use of services, and 7) the role of the private sector. The 4th chapter details existing policies which support women's sexual and reproductive health needs. The report concludes with seven recommendations regarding the development of a "national strategy for protection of the sexual and reproductive health of Ugandan women."

23. Kyamureku PT, Contradictions in human rights and social attitudes: case studies of abortion in Uganda, *Initiatives in Reproductive Health Policy*, 2000, 3(2):8.

- Ugandan women seeking abortion face severe punishments, which are more often the result of traditions and culture than a requirement of the law. Women do not understand legal codes and women's rights: they act out of ignorance and fear of how society might judge them.
- **Abstract:** In Africa and in many developing countries, there are many unwritten rules that apply to women. These unwritten rules and regulations, though referred to as culture or tradition, keep women in bondage and in a subservient status to men. Moreover, these

regulations limit women's right, health, and development and determine women's access to abortion and other health care. In contrast to these traditional views, many countries, including Uganda, have written constitutions with sections that provide the "Protection and Promotion of Fundamental and Other Human Rights and Freedoms". In this article, two case studies are presented that highlight contradictions between culture and written law and explore questions of human rights as they confront social attitudes in Uganda. Both stories relate the sufferings of two teenagers who became pregnant out of wedlock. It is noted that Ugandan women seeking abortion face severe punishments, which are more often the result of traditions and culture than a requirement of the law. Society and women in particular do not know or understand legal codes and women's rights, thus they act out of ignorance and fear of how society might judge them. Given the increasing effects of these structural adjustments policies in Africa, safe and legal abortion should be an issue of immediate concern. [from POPLINE]

24. Kyomuhendo GB, Low use of rural maternity services in Uganda: impact of women's status, traditional beliefs and limited resources, *Reproductive Health Matters*, 2003, 11(21):16-26.

- Traditional expectations which regard pregnancy as a test of endurance do not support women seeking care for pregnancy-related problems, 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).
- The study was carried out from November 2000 to October 2001. A cross-sectional and descriptive design was adopted, utilizing qualitative and quantitative data collection methods- focus group discussions (FGDs), key informant interviews, a quantitative survey and maternal death enquiries. A total of 808 women with more than one birthing experience were interviewed in the quantitative survey. Several villages (clusters) were randomly selected from each of the two counties in the district. In each village, all households with eligible women were interviewed using a pre-tested questionnaire with both open and closed questions. A total of 24 FGDs were also held, involving 240 participants (with men only and women only in each of five localities).

25. Lalonde AB, Okong P, Mugasa A and Perron L, The FIGO save the mothers initiative: the Uganda-Canada collaboration, *International Journal of Gynecology and Obstetrics*, 2003, 80(2):204-212.

- This was a demonstration project to improve emergency obstetric care (EOC) in Uganda (1998-2000) showed that interventions (including more and better trained personnel, upgraded facilities, educational programs, workshops to influence attitudes of providers, and improved communication and transport) led to much improved care. For example, met need for EOC rose from 4% to 47% and the case fatality rate dropped from 9.4% to 1.9%.

26. Levin A et al., Costs of maternal health care services in Masaka district, Uganda, Bethesda, Maryland: Abt Associates, 1999, No. 16.

- Abstract: This study evaluates provider and consumer cost of six maternal health services, along with selected quality indicators, at four health facilities and among community practitioners in Masaka District, Uganda. The study examines costs of

providing the services in order to examine the reasons behind cost differences, assess the efficiency of service delivery and determine whether management improvements might achieve cost savings without lowering service quality. Data collected by the Partnerships for Health Reform together with the Makerere University Institute of Public Health in May 1998 were used. These data include cost of maternal health services at a public and mission hospital, a public and mission health center, 17 private midwives, and 20 traditional birth attendants. Findings revealed that the total costs of routine maternal health services in the four facilities were found to be less than \$7.00 for antenatal care and less than \$35.00 for vaginal delivery. Obstetric complications were more costly due to the use of more and high-level personnel and materials. Cost for cesarean sections and post-abortion complications ranged from \$19.97 to \$86.48. Materials were considered as the most costly input for maternal health care as compared with other health services. [from POPLINE]

27. Lutalo T, Kidugavu M, Wawer MJ, Serwadda D, Zabin LS and Gray RH, Trends and determinants of contraceptive use in Rakai district, Uganda, 1995-98, *Studies in Family Planning*, 2000, 31(3): 217-227.

- This was a prospective 30-month study (1995-1998) in Rakai district. It was part of a randomized community-intervention trial (STD control for AIDS prevention) of 56 villages on secondary roads: all consenting adults aged 15-59 were enrolled and interviewed at 10-month intervals (but this study only used data from the baseline survey and the 30th-month follow up). Women's contraceptive use increased from 11% to 20%; male condom use from 10% to 17%. Women family planners were predominantly aged 20-39, married, better educated and had higher parity. Male condom users tended to be young, better educated, unmarried, with multiple sex partners. Self-perception of HIV risk increased condom use, but HIV testing and counseling had only modest effects.

28. Lwanga C, Abortion in Mulago Hospital, Kampala, *East African Medical Journal*, 1977, 54(3):142-8.

- This study of PAC patients at Mulago hospital (1973-1974) showed the following serious complications of PAC admissions: excessive hemorrhage 10%, infection 6%, peritonitis 1%, as well as a few cases of acute genital-area trauma.
- This was a study of PAC patients at Mulago hospital for 1 year (1973-1974). Treatment of 1,377 PAC cases: 179 oxytocin, blood transfusion 137, evacuation 772, 3 colpotomy, 5 laparotomy for peritonitis, 1 repair of uterus, not treated 280. Complications: excessive hemorrhage 137, infection 82, peritonitis 8, etc. A preponderance of adolescents with few pregnancies was noted.

29. Mbonye AK, Abortion in Uganda: magnitude and implications, *African Journal of Reproductive Health*, 2000, 4(2):104-08.

- In this 1995 study of 24 randomly selected districts examining abortion-related admissions at health facilities, about 8,300 abortion-related cases were recorded per 100,000 deliveries, based on health records. About 23% of abortion cases presented with serious complications.
- In this 1995 national study, only 28% of the surveyed facilities supplied blood and only 27% had ampicillin injections available.

- The study of 97 facilities (30 of which were hospitals) recorded 35,682 deliveries and 2,978 abortions (also 302 maternal deaths and 685 post-abortion complications). 46% of abortions were identified as spontaneous, 39% as induced. The distribution of abortion-related complications was: hemorrhage 52.2%, sepsis 34.8%, uterine perforation 8.7% and cervical injury 4.3%.
- Study design: random selection of 24 districts; all hospitals in district selected and 20% of lower units selected by stratified sampling; 1995 study of abortion-related health records; 30 hospitals and 67 health units.

30. Mirembe FM, Results and recommendations from a multi-centre study on risk factors associated with maternal mortality in Lesotho, Malawi, Uganda, and Zambia, paper presented at the First Regional Congress of the Medical Women's International Association, Near East and Africa Region, Nairobi, Kenya, Nov. 29- Dec. 3, 1993.

- This was a multi-country study of serious abortion complications (Uganda, Lesotho, Malawi, Zambia) took place in 1990-1992. Overall, 28% of maternal deaths were due to unsafe abortion.
- Abstract: A case-control hospital study involving 864 controls was conducted in Lesotho, Malawi, Uganda, and Zambia to identify risk factors for maternal mortality. There were 288 maternal deaths, 28% of which were abortion related. The study found that women age 35 years or older and those younger than age 17 years were at highest risk. The women who died were generally admitted to the hospital in poor condition, with the most common complications among older women and those with five or more previous deliveries being postpartum hemorrhage, ruptured uterus, and infection. Obstructed labor and infection dominated among the teenagers. Abortion was generally unsafe and self-administered; the most affected group was of age 25-29 years, parity 1-2, and single. Lack of or a low level of education among women and their spouses was associated with greater risk of maternal death, due to the underuse of health services, and poorer social and economic status and environment. Low levels of family planning use and short birth intervals were similar in both groups. Health centers were the most commonly used health facilities, although the women who died showed a greater tendency to use traditional birth attendants and village health workers when sick or in labor. The study also found a generally poor quality of maternity services. [from POPLINE]

31. Mirembe FM, A situation analysis of induced abortions in Uganda, *African Journal of Fertility, Sexuality And Reproductive Health*, 1996, 1(1):79-80.

- In this older study, more than two-thirds of PAC patients at Kampala's main teaching hospital were aged 15-19.
- This study by Mirembe in the early 1990s showed that, in the main teaching hospital in Uganda, 68% of abortion patients were 15-19-year-olds and 79% were still in school.
- Mirembe quotes study by Turyasingura (1984) that 35% of maternal deaths at Mulago hospital were abortion related, the 1992-1993 study it was only 7%. Desire to continue education (50%) and fear of parents (26%) were two leading reasons given for abortion. Sepsis and hemorrhage in 60% of patients; 15% had genital tract trauma. This latter complication seems to be becoming less prevalent over time.
- Abstract: Uganda has a total fertility rate of 7.3 children per woman and a population growing at the annual rate of 2.8%. The government is actively promoting family

planning on primarily a health basis. In Uganda, abortion is illegal except to save a mother's life. Despite such legislation, however, both induced and spontaneous abortion occurs in Uganda even when a mother's life is not in jeopardy. The rate of induced abortion is increasing, as evidenced by the growing rates of maternal mortality related to abortions registered in Ugandan hospitals. Research indicates that the majority of all induced abortions were among young, single, low parity women, most often in secondary school or university. A 1992 study by Bazira found the following reasons among women for terminating pregnancy: 50% did so out of a desire to continue their education, 25.7% feared their parents, 8.3% could not afford to care for a child, 3.0% had a spouse who did not want a child at that time, and 5.3% had completed their families. There is a low prevalence of contraceptive use among women who seek induced abortion, with lack of knowledge about contraception and the unavailability of contraceptives being the two main reasons for nonuse of contraception. Sepsis and hemorrhage comprised 60% of complications resulting from induced abortion. [from POPLINE]

32. Moore AM, Nakabiito C, Mirembe F, Prada E and Bankole A, How HIV status impacts child-bearing decisions: results from a qualitative study in Kampala, Uganda, paper presented at the annual meeting of the Population Association of America, Los Angeles, Mar. 30 – Apr. 1, 2006.

- This is an exploratory study of HIV-positive women in Kampala showed that almost all had at least one pregnancy since learning about their HIV status. Half of the HIV-positive women interviewed who became pregnant considered the abortion option yet decided against it, primarily because of their estimation of the health risks posed in conditions of highly restricted access and unsafe methods. HIV-positive women also feared discrimination from health care providers for being HIV-positive and pregnant.

33. Nakintu N, A comparative study of vaginal misoprostol and intravenous oxytocin for induction of labour in women with intra uterine fetal death in Mulago Hospital, Uganda, *African Health Sciences*, 2001, 1(2): 55-59.

- The sample consisted of 120 women with intrauterine fetal death who were randomly allocated to two groups. One group received misoprostol treatment; the other group oxytocin treatment.

34. Ndyomugenyi R, Neema S and Magnussen P, The use of formal and informal services for antenatal care and malaria treatment in rural Uganda, *Health policy and Planning*, 1998, 13(1):94-102.

- Not on abortion, but this study shows why many rural women do not attend clinics for ANC or deliver in facilities: cost and poor quality of service.

35. Neema S, Musisi N and Kibombo R, Adolescent sexual and reproductive health in Uganda: a synthesis of research evidence, *Occasional Report*, New York: Guttmacher Institute, 2004, No. 14.

- Not reviewed. Available at www.guttmacher.org.

36. Nuwaha F and Amooti-kaguna B, Predictors of home deliveries in Rakai district, Uganda, *African Journal of Reproductive Health*, 1999, 3(2):79-86.

- This study interviewed 211 women who had a delivery in the previous year in Rakai district (June 1997). A stratified random sample of women aged 15-45 was selected. 44.5% had delivered at home. The factors related to home delivery were: being migrants, lower education, non-Catholic, no formal work, more than one hour's walk from a clinic, not having had ante-natal care.

37. Nyanzi S, Nyanzi B and Bessie K, "Abortion? That's for women!" Narratives and experiences of commercial motorbike riders in south-western Uganda, *African Journal of Reproductive Health*, 2005, 9(1):142-161.

38. Nyanzi S, Nyanzi B and Bessie K, Contemporary myths, sexuality misconceptions, information sources, and risk perceptions of *Bodabodamen* in Southwest Uganda, *Sex Roles*, 2005, 52(1-2):111-119.

- In one of the few studies done with men in Africa about abortion, Nyanzi et al. 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. 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. 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 post-abortion 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.

39. Okong P, Biryahwaho B and Bergstrom S, Post-abortion endometritis-myometritis and HIV infection, *International Journal of STD and AIDS*, 2002, 13(11):729-732.

- Abstract: The objective was to explore if HIV-1 infection is a risk factor for post abortion endometritis± myometritis (PAEM) in an urban hospital in Kampala, Uganda. HIV-1 seroprevalence in women with and without post-abortion infection was established using two standard enzyme-linked immunosorbent assays. Fifty-two women with PAEM and 106 without PAEM infection were recruited. The HIV-1 seroprevalence was 17 (32.7%) among women with PAEM and 38 (36.5%) among women without post-abortion infection. HIV infection was not found to correlate with the risk for PAEM. HIV-1 seroprevalence in both groups was double that among antenatal clients in the same hospital, 14.6% in 1997. Life-threatening infections such as septicemia, peritonitis and pelvic abscesses were observed among 12 cases (23%). HIV-1 infection was not shown to be a risk factor for PAEM, but women with abortions with and without PAEM have a

higher prevalence of HIV-1 than antenatal clients.

40. Okong P, Byamugisha J, Mirembe F, Byaruhanga R and Bergstrom S, Audit of severe maternal morbidity in Uganda--implications for quality of obstetric care, *Acta Obstetrica et Gynecologica Scandinavica*, 2006;85(7):797-804.

- This study of “near miss” maternal morbidity in four referral hospitals in 1999-2000 found 685 cases of severe maternal morbidity of which 229 cases met the “near miss” criteria. Of the “near misses”, 38 (17%) were from post-abortion complications. More than half of “near miss” women began the episode at home and delayed seeking care. Also, more than half received sub-standard care in the hospital. “Near misses” are hospital patients who come close to death, in this case women who have severe maternal complications, including those who have aborted. The criterion for inclusion as a “near miss” is generally if there is organ failure or organ dysfunction.
- Study design: Audit of four referral hospitals of “near miss” maternal morbidity. 21 month study of records supplemented with interviews: 685 severe morbidity cases of which 229 met “near miss” criteria; 55,803 births, 269 maternal deaths (MMR = 482). Abortion-related: 13 sepsis cases. 25 hemorrhage cases (16.6% of near misses).

41. Orinda et al., A sector-wide approach to emergency obstetric care in Uganda, *International Journal of Gynecology and Obstetrics*, 2005, 91(3): 285-291.

- This needs assessment of health facilities in Uganda in 2003 showed a low level of preparedness for emergency obstetric care. E.g., 34 of 36 facilities lacked blood transfusion capacity; missing EOC “signal functions” varied from 25% to 95% across health facilities.

42. Population Reference Bureau (PRB), *Reproductive Health in Policy and Practice: Case Studies in Brazil, India, Morocco, and Uganda*, Washington, DC: PRB, 1998.

- Availability of contraceptives in government programs is problematic. Decentralization took place in mid-1990s, but many district administrators are not even aware of the health ministry’s recommendations about reproductive health. The supply of modern contraceptives is often inadequate; the median distance for rural women to reach family planning services is 12 miles. Community-based distribution programs are ineffective. Other barriers to use of contraception include misconceptions about modern methods and lack of spousal support or even hostility.

43. Prada E et al., Abortion and post-abortion care in Uganda: a report from health care professionals and health facilities, *Occasional Report*, New York: The Alan Guttmacher Institute, 2005, No. 17.

- Abortion-related complications are more common among rural women, most of whom go to nonprofessional providers, and less common among urban women, most of whom go to medically trained providers.
- Based on the opinions of knowledgeable key informants, we estimate that 40% of all women who obtain abortions are likely to experience complications but receive no treatment. Applying this proportion to estimated annual total number of abortions indicates that about 57,000 Ugandan women each year are in this situation. The chance

of receiving treatment is believed to be lowest among poor women living in rural areas and highest among non-poor women in urban areas. (see also Singh et al. 2006)

- Health professionals recommended the following to reduce unsafe abortions: Publicize the health risk involved in unsafe abortion; improve access to effective contraception; and general educational activities.
- The health professionals survey was a purposive sample of experts selected from Kampala and seven surrounding districts using the criteria of affiliation, specialty and reputation for knowledge and experience (N = 53).

44. Rabb M, *Nurse-midwives expand post-abortion care at the community level, Chapel Hill, North Carolina: University of North Carolina at Chapel Hill Program for International Training in Health, 2000.*

- This pilot test (around 2000) of public-health-system midwives to impart PAC training, as part of PRIME II project (USAID), showed that three-quarters of MVA procedures were done by midwives after training; 70% of clients received a family planning method; and 64% of clients received STI counseling.
- Abstract: The PRIME-assisted initiative in Kenya demonstrated clearly that trained nurse-midwives using MVA can provide safe, high-quality PAC services at the community level. After the training, virtually all the nurse-midwives achieved acceptable standards of performance, resulting in a rapid expansion of PAC services. Over 80% of post abortion care patients received family planning counseling and 100% of those who did not want to become pregnant accepted a contraceptive method. There were no complications related to the MVA procedure. Not surprisingly, the number of women seeking PAC services at these pilot primary care facilities increased. In fact, the availability and use of PAC services at the community level has helped reduce the number of women seeking post abortion care at referral facilities, where they often arrive with complications exacerbated by delays and difficulties in travel. In Uganda, the pilot PAC training improved women's access to post abortion care, and to the other reproductive health services offered in conjunction with PAC. During the course of the project, more than half of the post abortion patients seeking care presented with incomplete abortion below 12 weeks uterine size. All of them received MVA treatment, which was performed by the newly-trained midwives in three quarters of the cases. There were no procedure-related complications. Among all the post abortion patients, 70% received a family planning method at the time of treatment, 64% received STI/HIV counseling, and 33% received appropriate nutrition counseling.

45. Sibbald B, *Ugandan government resolves to make safe motherhood a priority, Canadian Medical Association Journal, 2007, 177(3): 244-245.*

- This is a news report on a safe motherhood resolution passed by Uganda parliament in Dec 2006: maternal mortality efforts were specifically put into the 2007 budget—for first time; 16 women die each day of maternal mortality; Save the Mother's MPH leadership program started in 2005 at Uganda Christian University in order to foster effective advocacy.

46. Singh S, Prada E, Mirembe F, Kiggundu C, The incidence of induced abortion in Uganda, *International Family Planning Perspectives*, 2005, 31(4):183-191.

- In 2003, a study of a national representative sample of health facilities that provide post-abortion care found that 110,000 women were treated for abortion complications. Indirect techniques estimated that 85,000 of these women were treated for induced abortion complications and 25,000 women for spontaneous abortions. Based on these numbers and data collected from health professionals were knowledgeable about abortion service provision, the total number of induced abortions was estimated to lie between 212,000 and 381,000, with a central (and recommended) estimate of 297,000 induced abortions. This compares to 1.25 million live births during the same period. Using the central estimate, this translates to 54 induced abortions per 1,000 women (15-49) and 19 induced abortions per 100 pregnancies.
- Study design: Health facilities survey (313 facilities interviewed including 93 hospitals, 58 Level IV health centers, 122 Level III health centers and 40 private midwives) obtained data on numbers of PAC admissions; also, Health professionals survey (53 health professionals) obtained data on proportion of women with complications who received facility-based treatment. Method worked backwards from number of women treated for complications after induced abortions to total number of abortions.

47. Singh S et al., *Unintended Pregnancy and Induced Abortion in Uganda: Causes and Consequences*, New York: Guttmacher Institute, 2006.

- An estimated 775,000 women in Uganda had unintended pregnancies (including unplanned births and abortions) in 2003.
- The gap between ideal and actual family size more than doubled in Uganda between 1988 and 2000, reflecting a growing desire for smaller families that has not been matched by an increase in the use of modern contraceptives. Many women in Uganda do not use modern contraceptives because they distrust them and because accurate information about the safety of these methods is not available. In fact, one-third of all Ugandan women of reproductive age want to stop or delay further childbearing but are not using a modern contraceptive method.
- More than half of all abortions are carried out by medically trained providers (doctors, nurses, midwives). The remaining procedures are performed by nonprofessionals, including pharmacists, traditional providers and women themselves. The methods used by medically trained professionals, especially in urban areas, are safer than those used by non-professionals. Trained professionals rely primarily on dilation and curettage (D&C) and manual vacuum aspiration (MVA); lay practitioners use a variety of often unsafe methods, including insertion of sharp objects into the uterus, a wide range of herbal remedies, medications and drinks made from caustic substances.
- The more highly trained the practitioner, the more costly the procedure. Estimates suggest that, on average, physicians charge more for abortions (\$25-\$88 USD) than do nurses and nurse-midwives (\$14-\$31 USD), or traditional healers, herbalists and lay practitioners (\$12-\$34 USD). Pharmacist fees range between \$5 and \$14 USD. Note that at the time of survey, 2003, 1 USD = 1,600 shillings.
- The more highly trained the practitioner, the less likely an abortion will place a woman at risk. According to estimates, serious health consequences—including hemorrhage, infection or damage to the uterus—result from one in four abortions performed by

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

- Poor women are twice as likely as non-poor women to induce their own abortions; and only one-third as likely as non-poor women to have their abortions performed by a physician. A woman is more likely to have a safe abortion if she can afford the services of a medically trained professional. However, not all abortions performed by these trained providers are safe.
- Only six in ten Ugandan women who experience complications from abortion are believed to receive treatment within the country's formal health care system.
- Of women with abortion complications who receive care, about one-third go to government and private hospitals, one-half go to government and private health centers, and the remainder are treated by private midwives. Almost six in ten treated women receive their care in public health facilities, one-quarter in nongovernmental organization facilities and the remainder in private facilities run by midwives.
- Based on the opinions of knowledgeable key informants, we estimate that 40% of all women who obtain abortions are likely to experience complications but receive no treatment. Applying this proportion to estimated annual total number of abortions indicates that about 57,000 Ugandan women each year are in this situation. The chance of receiving treatment is believed to be lowest among poor women living in rural areas and highest among non-poor women in urban areas. (see also Prada et al. 2005)
- The proportion of physician-performed abortions that lead to serious health consequences is many times higher in Uganda than in Western countries. This suggests that some Ugandan doctors have not been properly trained in the use of D&C or are working under unsafe conditions.
- Policymakers and health planners need to consider and debate strategies to address the high levels of unsafe abortion and low levels of contraceptive use in Uganda.
- The political will exists to improve reproductive health care and to increase contraceptive use in Uganda, but the financial resources currently available are insufficient to achieve these goals.
- To reduce the grave health consequences and substantial long-term costs of unsafe abortion, resources should be directed at improving the availability and quality of post-abortion care for women with complications.
- Wider training in the use of manual vacuum aspiration—a very safe method when used correctly—would reduce the frequency and severity of complications from abortions performed by medically trained professionals.
- Education in schools and other community settings, as well as through the mass media, is needed to emphasize the health and societal benefits of family planning.
- Improving knowledge about, access to and use of effective contraceptives would lead to lower rates of unwanted pregnancy and induced abortion.
- Men should be enlisted in efforts to improve reproductive health conditions among couples in Uganda.

48. Uganda Bureau of Statistics (UBOS) and Macro International, *Uganda Demographic and Health Survey 2006*, Calverton, MD, USA: Macro International; and Uganda: UBOS, 2007.

- The proportion of Ugandan births that were unplanned rose from 29% in 1995 to 38% in 2000–2001, to 46% in 2006, suggesting that the level of unintended pregnancy overall was also increasing.
- Current contraceptive use by currently married women aged 15-49 is still relatively low and has increased slowly over the past decade - in 2006 it was 24.4%, up from 15.4% in 1995 and 18.6% in 2000-2001; moreover, current use of modern methods is 18.5%. In 2006, unmet need stood at 40.6% of married women 15-49 (60% of the unmet need is for spacing and 40% for limiting). The highest levels of unmet need were among older, rural, uneducated, poor women.
- In the Demographic and Health Survey of 2006, almost half of adolescent women aged 15-19 (43%) have had sex and the median age at first intercourse for women aged 20-24 at time of survey was 16.9 years.
- The median age at first intercourse for women aged 20-24 at time of interview was 16.3 years in 1995, 17.1 years in 2000-2001 and 16.9 years in 2006. Source: last three DHS surveys.

49. United Nations Population Division, *World Abortion Policies 2007 Wall Chart*, New York: United Nations, 2007.

- Under the Ugandan Penal Code of 15 June 1950 (sections 136-138, 205 and 217) the performance of abortions is generally prohibited. The abortion provider, the woman herself or anyone who supplies the means to procure an abortion is subject to various terms of imprisonment. Nonetheless, under other provisions of the Penal Code, an abortion may be performed to save the life of a pregnant woman. Section 217 of the Code provides that a person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon an unborn child for the preservation of the mother's life if the performance of the operation is reasonable, having regard to the patient's state at the time and to all the circumstances of the case. Moreover, in the case of rape, abortion is sanctioned if it prevents the woman from becoming "a physical and mental wreck" and thus preserves the pregnant woman's physical and mental health.

50. Weeks A, Alia G, Blum J, Winikoff B and Ekwaru P, *A randomized trial of misoprostol compared with manual vacuum aspiration for incomplete abortion*, *Obstetrics and Gynecology*, 2005, 106(3):540-547.

- This study consisted in a randomized treatment of 317 hospital patients diagnosed with incomplete first-trimester abortion to misoprostol treatment or MVA treatment. All women were followed up 1-2 weeks later.

51. Weeks A, Lavender T, Nazziwa E and Mirembe F, *Personal accounts of 'near-miss' maternal mortalities in Kampala, Uganda*, *British Journal of Obstetrics and Gynecology*, 2005, 112(9):1302-1307.

- A recent "near-miss" maternal mortality qualitative study in Mulago hospital showed that such women experience a predominant feeling of powerlessness, both within and outside

the hospital. Women experienced difficulty in getting both practical and financial help as well as in failing to gain rapid access to care. Medical mistakes and delays in referral were evident, especially in rural health centers. Overcrowding, long delays, shortages and inhumane care were other problems mentioned. Four of 30 the cases interviewed were septic abortions.

- Study design: Semi-structured qualitative interviews of “near-miss” maternal mortality cases at Mulago hospital (N = 30); double analysis of interview content.

52. Wolff B, Blanc A and Ssekamatte-Ssebuliba J, The role of couple negotiation in unmet need for contraception and the decision to stop childbearing in Uganda, *Studies in Family Planning*, 2000, 31(2):124-137.

- This study used survey and focus-group data from the 1995-1998 Negotiating Reproductive Outcomes study. It was found that indirect forms of communication predominated, leading to over-estimation of partners’ demand for additional children. Partner opposition led to increased unmet need and a shift towards traditional methods of contraception.

53. Wycliffe B, Abortion and the law in Uganda, 1990, unpublished. [from POPLINE]

- Abstract: This thesis examines the existing abortion law in Uganda to reveal how it operates and its limitation as an anti-abortion social vehicle. The various and competing interests of an unwilling mother, a fetus, and society are considered, and other legal systems are reviewed for the purpose of comparison. As a result of this analysis, potential legal reforms are suggested for Ugandan abortion law. The first chapter of the paper presents its objectives, hypothesis, and research methodology as well as the results of a literature review and the theoretical framework. Chapter 2 looks at the law and its operation in terms of its history, what the law actually says, what constitutes an offense, what constitutes preparatory and inchoate offenses, cases where abortion is permitted, defenses, the punishment, and a critique of the law. This chapter notes that the law lacks clarity since it allows abortions to save a mother's life but does not attempt to define "health" or "life." The law is also found to be ineffective since the incidence of illegal abortion is increasing. Because the causes of abortion exist outside of the purview of the law, legal reform can not solve the problems attendant with abortion. The third chapter presents arguments for and against abortion from the point of view of the fetus, the mother, and society. The conclusion of this chapter notes that the real problem is how to prevent unwanted pregnancies. Chapter 4 discusses reforms and recommendations, including measures to control criminal abortion, education, sex education, family planning, moral rehabilitation, adoption, fostering, and the role of various women's organizations. In conclusion, the problem of abortion can not be solved legally, but the problems attendant with illegal abortion can be solved by liberalizing abortion laws.

54. Zabin L and Kiragu K, The health consequences of adolescent sexual and fertility behavior in Sub-Saharan Africa, *Studies in Family Planning*, 1998, 29(2):210-232.

- Not reviewed.

Reproductive Health Indicators – Uganda	
Number of induced abortions per year, 2003	297,000
Abortion rate (number of induced abortions per 1,000 women aged 15-49), 2003	54
Abortion ratio (number of induced abortions per 100 pregnancies), 2003	19
Hospitalization rate (number of women hospitalized for post-abortion complications per 1,000 women), 2003	14.6
Maternal mortality ratio (maternal deaths per 100,000 live births), 1997-2006	435
Median age at first sexual intercourse, women aged 25-29, 2006	16.7 yrs.
Median age at first marriage, women aged 25-29, 2006	18.0 yrs.
Percentage of pregnancies that are unintended, 2003	50 %
Percentage of births that are unplanned, 2006	46 %
Percentage of births that are unwanted, 2006*	13 %
Mean number of unplanned births per woman, 2004-2006	1.6 births
Percent of currently married women aged 15-49 with unmet need for family planning, 2006	41 %
Percent of women aged 15-49 currently using a contraceptive method, 2006	20 %
Percent of women aged 15-49 currently using a modern contraceptive method, 2006	15.4 %
Sources: UBOS 2007, for unplanned births, unmet need, contraceptive prevalence, first sexual intercourse, maternal mortality; Singh <i>et al.</i> 2005, for four abortion indicators and unintended pregnancies	
* 46% of births were unplanned at the time of conception. However, after children were born, most became wanted by their mothers and the percentage of children who were still unwanted fell to 13%.	