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Ugandan opinion-leaders' knowledge and perceptions of unsafe abortion

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While laws in Uganda surrounding abortion remain contradictory, a frequent interpretation of the law is that abortion is only allowed to save the woman's life. Nevertheless abortion occurs frequently under unsafe conditions at a rate of 54 abortions per 1000 women of reproductive age annually, taking a large toll on women's health. There are an estimated 148,500 women in Uganda who experience abortion complications annually. Understanding opinion leaders' knowledge and perceptions about unsafe abortion is critical to identifying ways to address this public health issue. We conducted in-depth, semi-structured interviews with 41 policy-makers, cultural leaders, local politicians and leaders within the health care sector in 2009–10 at the national as well as district (Bushenyi, Kamuli and Lira) level to explore their knowledge and perceptions of unsafe abortion and the potential for policy to address this issue. Only half of the sample knew the current law regulating abortion in Uganda. Respondents understood that the result of the current abortion restrictions included long-term health complications, unwanted children and maternal death. Perceived consequences of increasing access to safe abortion included improved health as well as overuse of abortion, marital conflict and less reliance on preventive behaviour. Opinion leaders expressed the most support for legalization of abortion in cases of rape when the perpetrator was unknown. Understanding opinion leaders' perspectives on this politically sensitive topic provides insight into the policy context of abortion laws, drivers behind maintaining the status quo, and ways to improve provision under the law: increase education among providers and opinion leaders.

Keywords Uganda, opinion leaders, unsafe abortion, in-depth interviews, abortion law

KEY MESSAGES

- Only half of the respondents knew when abortion was legal in Uganda.
- Opinion leaders are aware that abortion restrictions endanger women's lives but perceive that liberalization of the law could lead to increased use of abortion with negative social consequences.
- Abortion liberalization was most widely supported in cases of rape, in particular when the identity of the man was not known.

Introduction

In Uganda, 34% of married women have an unmet need for contraception (Uganda Bureau of Statistics (UBOS) and ICF International Inc. 2012) which exposes a large portion of the population to unintended pregnancy and induced abortion. Singh and colleagues found an annual rate of 54 induced abortions per 1000 women aged 15–49 (Singh *et al*. 2005). Uganda's rate is the highest yet found in Africa and is double the rate found in Burkina Faso, Rwanda and Ethiopia (Singh *et al*. 2010; Sedgh *et al*. 2011; Basinga *et al*. 2012). The poor conditions in which most abortions take place result in high rates of abortion-related morbidity and mortality: 148 500 Ugandan women experienced abortion complications in 2003 (Singh *et al*. 2005; Jagwe-Wadda *et al*. 2006; Singh *et al*. 2006), the most recent year for which data are available. Twenty-six per cent of Uganda's maternal mortality is attributed to unsafe abortion (The Republic of Uganda 2008).

Surjadjaja and Mayhew (2011), examining the public policy impact of research, find that an understanding of power structures and communication operating in abortion debates is crucial for policy change, and that understanding power structures includes knowing stakeholders' opinions on the issue. Documenting opinion leaders' knowledge and perceptions of unsafe abortion can identify policy barriers to safe abortion legislation as well as possible avenues through which to increase access to safe abortion (Villela and Araujo 2000; Yam *et al*. 2006; van Dijk *et al*. 2007; Okonofua *et al*. 2009). In order to build on existing efforts to understand the policy context surrounding unsafe abortion in Uganda, we conducted a qualitative study to understand opinion-leaders' perceptions of abortion-related topics which are informing their decision-making about abortion. Specifically, we set out to:

- assess the information policy-makers had about the current legal situation regarding abortion;
- understand what they believed to be the consequences of the current restrictions on abortion;
- their perceptions of the consequences of increasing access to safe abortion; and
- whether there were possible reasons for abortion that opinion leaders were more sympathetic to supporting.

Abortion law and practice in Uganda

Abortion is regulated in all countries. Countries with the most conservative abortion laws do not allow abortion under any circumstances. In countries with more permissible, i.e. liberal, laws, abortion is still restricted by gestational age at which a woman can obtain an abortion, the number of health care providers who need to approve her abortion, reasons for seeking an abortion, disallowing different types of abortion and whether mid-level health providers are allowed to perform abortions. Abortion policy can be created in the Constitution (Kenya), the Penal Code (Rwanda), international agreements (The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, commonly known as the Maputo Agreement), legal cases (USA and Colombia), and health-policy guidelines (Uganda). These multiple official documents sometimes state contradictory information, as is the case in Uganda.

Uganda's abortion laws are contradictory and ambiguous (Center for Reproductive Rights 2012). Section 224 of the Ugandan Penal Code states that abortion is allowed to preserve a woman's life while case law has further protected abortion for mental and physical health [see *Rex v. Bourne (1938)*] (Center for Reproductive Rights 2012). There is disagreement about whether there exists the requirement that a health care provider must consult with one or two other health care providers, physicians or specialists before providing an abortion. While this is commonly understood to be the case, this stipulation is not in the constitution, any codes of conduct, or any laws or policies (Center for Reproductive Rights 2012). The Ministry of Health has issued abortion provision guidelines that go beyond the current legal grounds for abortion provision including allowing abortion in cases of defilement (i.e. sex with a minor), rape and incest (Reproductive Health Division 2006), yet there is no guidance on how to carry out the written policy, preventing implementation. The common interpretation of the law in Uganda by providers and policy-makers alike is that abortion is illegal on all grounds. Health workers do not even provide procedures permissible under the current law. Uganda only signed the Maputo Protocol in 2010, 5 years after it was signed by most other countries, and with reservations (The African Union Commission 2006). The two articles on which Uganda reserved its endorsement were on the right to control one's fertility and on access to abortion services (Center for Reproductive Rights 2012).

Post-abortion care (PAC) is always legal and is widely available at the level of health centres and all other higher-level facilities in Uganda (Singh *et al*. 2005). The *2006 National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights* specifies that health care providers, including mid-level providers, be trained to provide safe abortion and PAC (Reproductive Health Division 2006), but there are no numbers on how many providers have been trained to perform PAC or whether they have access to the appropriate equipment. In June 2009, the Ministry of Health trained doctors, nurses and midwives in Level III health centres, Level IV health centres and hospitals in 10 districts on misoprostol for management of post-partum haemorrhage (PPH). It is not clear how widely misoprostol has been further disseminated in government health facilities. Only in November 2011 was misoprostol approved by the National Drug Authority to treat missed abortions, incomplete abortion and therapeutic abortion (National Drug Authority 2011). Recent estimates of the cost of PAC nationally to the government was $13.9 million per year (Vlassoff *et al*. 2012). No information exists about what is taking place in the private sector.

One previous qualitative study in Uganda with policy-makers published its findings in the grey literature. That project which interviewed 32 Members of Parliament (MPs) using semi-structured interviews found that half of their respondents were ill-informed about the legal situation regarding abortion, often stating that abortion was always illegal. They also found that MPs underestimated abortion's contribution to maternal mortality, indicating a lack of awareness of the problem. MPs consider their constituencies strongly opposed to abortion although MPs themselves expressed the most support for abortion in cases of rape (Wibecan and Mato 2009). Regarding PAC, they found that most MPs supported PAC and felt that PAC provision in their communities could be improved. The authors conclude that experiences of loved ones with unintended pregnancy and rape held a great deal of power for MPs. This included MPs from

the North who had witnessed sexual violence and its consequences from the rebel Lord's Resistance Army occupation and were thus inclined to be more supportive of abortion than other MPs (Wibecan and Mato 2009). Yet the fact that their report only appeared in the grey literature, did not ground itself in the existing literature, that the interviewers were non-Ugandans, and that they misrepresented their small sample with claims of representativeness, makes us feel that this is the first rigorously done study to present the knowledge, attitudes and opinions of policy-makers on abortion in Uganda.

Data from providers and policy-makers in other African countries, some with more permissive laws than Uganda, demonstrate similarities across the continent regarding lack of familiarity with the law and discomfort addressing issues of maternal health. South Africa liberalized its abortion law in 1996, yet a qualitative study conducted with health care providers in the Western Cape identified a lack of familiarity with the law, fear of discrimination against non-medical staff, fear of discrimination by other staff, lack of providers trained to perform abortion and a lack of facilities in rural areas (Harries *et al*. 2009). Ethiopia liberalized its abortion law in 2005; yet stigma towards abortion and passive resistance on the part of medical providers have prevented women from accessing abortion under the framework that the law permits (Abdi and Gebremariam 2011). Five years after the law change, over half of the medical providers in Addis Ababa sampled in Abdi and Gebremariam's study did not agree that women have the right to decide to have a legal abortion (Abdi and Gebremariam 2011). Abortion law in Nigeria is interpreted as strictly as the abortion law is in Uganda. In their qualitative work with policy-makers examining abortion, Okonofua and colleagues found that policy-makers in Nigeria seemed to be guided more by religious and moral beliefs than by evidence. 'Policymakers, being politicians and career officials, generally do not wish to jeopardize their careers, and therefore tend to align with the most vociferous public opinion on controversial issues' (Okonofua *et al*. 2009, p. 200), which in Africa is generally the Church. Insights from these other countries were instructive in shaping the study design and research objectives for the present study.

This study attempts to fill the gaps that remain in what is known about Ugandan policy-makers' knowledge and attitudes about abortion. By interviewing not just MPs but also other policy-makers and opinion-leaders at the national level as well as the district level, we gathered information from opinion-leaders who provide leadership among the constituencies of MPs. The district-level respondents' opinions matter greatly because health care and decision-making have become extremely decentralized in Uganda and furthermore, these individuals are opinion-leaders within their communities. This new body of evidence builds on Wibecan and Mato by identifying similarities and differences using another qualitative sample of opinion-leaders to examine their knowledge and attitudes towards abortion in the hopes of identifying pathways that would be most effective in addressing unsafe abortion in Uganda.

Methods

We conducted in-depth, semi-structured interviews with policy-makers, service providers, and cultural leaders in the capital of Kampala as well as in three district local governments in Uganda in 2009–10. Including district-level policy-makers was important since a great deal of health care provision has been decentralized in Uganda and, furthermore, health policy implementation is done at the district level. In addition, the Executive branch is reluctant to take positions that are not popular in the districts, making district-level decision-makers influential policy-makers. The co-principal investigators (A.M.M. and R.K.), in collaboration with knowledgeable interviewers, identified the primary ministries, agencies and organizations that are the leaders on reproductive health in Uganda. Individuals within those institutions were purposively selected based on their leadership positions because they held privileged positions related to policy formulation or policy operationalization. The sample was decided upon by the co-principal investigators (A.M.M. and R.K.) with significant input from two senior advisors on the project as well as further review from members of the project's Advisory Committee which consisted of obstetricians/gynaecologists, representatives of national and international non-governmental organizations involved in the provision of reproductive health services as well as academics with a wealth of experience in abortion-related research.

In Kampala, sampling included individuals within the National Parliament, ministries and national organizations. In the districts, sampling included individuals holding local leadership and administrative posts in the health sector. The research team paid visits to the offices of the selected participants to secure appointments for interviews. In cases where respondents were unavailable, their phone contacts were obtained so an appointment could be fixed to schedule an interview. Refusals took the form of a 'soft refusal', i.e. someone continuously saying that they were travelling, too busy to meet, repeatedly pushing an appointment back or not showing up at an agreed upon time. This only happened in Kampala and in only four cases (response rate: 41/45). Each respondent was read an informed consent form before beginning the interview. All respondents who were administered the consent form agreed to be interviewed.

Our final sample was 15 national-level opinion-leaders from Kampala and then eight or nine opinion-leaders from each of the three districts sampled ($n = 41$). The interviews in Kampala were with national figures including: key officials in the Ministry of Health; parliamentarians from pertinent committees such as Parliamentary and Legal Affairs, Population and Food Security, Women, and Social Services; public and private hospital administrators; officials of medical bureaus responsible for implementing health policies provided by faith-based organizations; and cultural leaders from the ethnicities of the areas in which we were carrying out our study.

While it is impossible to capture ethnic representation of a country as diverse as Uganda in a qualitative study of this size, we selected districts that represent the largest ethnic groups: Bushenyi district in the West captured Banyankore respondents, Kamuli district in the East captured Basoga respondents, and Lira district in the North captured Lango respondents. Selecting respondents of different ethnicities allowed us to capture dimensions of culture as culture affects abortion attitudes. Interviews in the districts were held with senior

officials incharge of health services and councillors at sub-county Local Council Three and District level Five.

The interview guide was based on in-depth interviews carried out with stakeholders in Nigeria (Okonofua *et al*. 2009) and then modified for the Ugandan context based on our past research (Jagwe-Wadda *et al*. 2006; Singh *et al*. 2006; Moore *et al*. 2011) with further input from the Nigerian study's principal investigator (Okonofua) about what he felt, in retrospect, had been missing from his interviews. The interviews covered opinion-leaders' current knowledge of the contribution of unsafe abortion to maternal mortality; their understanding of abortion as a social problem; their knowledge of the abortion law and its known applications; attitudes towards PAC and current abortion access; their perceptions of the consequences of current restrictions on induced abortion; attitudes regarding how abortion complications should be managed; their opinions about what changes can and should be made to supply chains to improve manual vacuum aspiration (MVA) access; the extent and depth of both support and opposition towards abortion liberalization; perceptions of what an abortion law that allowed induced abortion under a broader range of circumstances would do to the demand for abortion; and opinions about how a liberalization of the abortion law would need to be operationalized. The questions were framed in the context of the current political situation including recent public discourse, national legislation and international agreements including the Maputo Protocol and Millennium Development Goal #5 (MDG5) on reducing maternal mortality.

The interviews were conducted by interviewers with a great deal of experience in conducting in-depth qualitative interviews in the area of reproductive health, if not abortion. At the national level, interviewers were senior researchers who carried political weight. Research assistants at the Makerere Institute of Social Research (MISR) conducted the interviews in the districts. Pre-testing of the data collection tool was done in one of the peri-urban districts near Kampala (Wakiso), and the field protocols and instrument were revised in response to the pre-test. The duration of the interview was between 45 min and 1 h. The interviews were conducted in English as well as three local languages. Participants did not receive tokens of appreciation as they were interviewed in their official capacity, although they were thanked for their time. The research protocols were approved by the Institutional Review Board of the Guttmacher Institute and the Uganda National Council for Science and Technology and a further approval was obtained from the Office of the President of Uganda.

Interviews were translated, when necessary, and transcribed and then coded into an existing node structure in NVIVO (QSR International, Melbourne, Australia) using content analysis. The node structure was created from the major themes and minor sub-themes in the interview guide. Applicable text was matched with relevant themes. Coding was done by members of the interview team. Analysis was conducted by two of the co-authors (A.M.M. and D.C.B.). Themes of interest including applicable quotes from respondents were used to construct matrices in Excel which allowed for the sorting of text. This sorting allowed us to identify commonalities as well as variations in our sample. Matrices were then summarized into bullet points, and the bullet points were then turned into text. We identify illustrative quotes with the respondent's gender, a general identification of their professional role, and finally, their location. Care was taken not to include specific job titles to respect respondents' confidentiality.

Results

Of the 41 respondents, 25 were men; most were 45–54 years of age, and Protestant (see Table 1). Most had been in their position for <4 years. We present their responses here as a cross-section of opinions from leaders in Uganda.

When is abortion allowed in Uganda?

Only half of the respondents knew that abortion is allowed in Uganda in cases where the mother's life is at risk, although there was confusion regarding what was legal against what was done in practice. Almost all the respondents who knew abortion was allowed under this condition were based in Kampala. Only three of these mentioned that two doctors must certify the

Table 1 Descriptive statistics of Uganda opinion-leaders sample, interviews with Ugandan opinion-leaders, 2009–10

Category	*n*
Gender	
Female	16
Male	25
Age	
25–34	3
35–44	9
45–54	15
≥55	7
Missing	7
Religion	
Protestant	16
Anglican	6
Catholic	12
Muslim	4
Christian	2
Undeclared or missing	1
Location	
Kampala	16
East (Kamuli district)	9
West (Bushenyi district)	8
North (Lira district)	8
Average duration in position (years)	
Months to 4 years	24
5–9 years	9
10–14 years	3
>15 years	4
Missing	1

legality of the abortion. And, only this respondent spoke to the impracticality of this stipulation.

> I(nterviewer): So, to the best of your knowledge, Honorable, under what circumstances is abortion legal in Uganda?
> R(espondent): When the life of the woman's in danger and of that woman in danger, it has to be approved by two doctors, two consultants, and when does my woman reach the consultants? The woman I represent? The people who can see consultants are the people who are in Kampala central, and do even those consultants have the time to look those issues? They are already overloaded with work. (Female, chairperson of a relevant parliamentary association, Kampala)

One-quarter of the sample ($n = 11$) believed that abortion was not allowed under any circumstances in Uganda. It is noteworthy that almost all of these respondents were district-level respondents including two Secretaries for Health at the district level. Four respondents (three district-level and one national-level) stated that they did not know what the law stated about abortion in Uganda. Two district-level respondents stated that abortion was allowed in circumstances when the law in fact does not allow it.

Perceived consequences of restrictions on abortion

Opinion-leaders identified dire health consequences of the current restrictions on abortion, acknowledging that urban women were less affected by the legal restriction in place than rural women. Female respondents more commonly than male respondents identified negative social consequences stemming from women having unwanted children or because they died in the process of attempting to obtain an abortion. Men more commonly stated that restrictions on abortion prevented abortions from occurring which was seen as positive by respondents who gave this answer.

Health consequences

When opinion-leaders were asked about the consequences of the current legal restrictions to abortion, most commonly respondents spoke of medical complications. Respondents stated that the current restrictions push women to depend on hidden services of unreliable quality in unsafe environments. Long-term health effects such as infertility were named as consequences of abortion being illegal by just under half of the sample.

> Women are pushed into putting [bicycle] spokes in their private parts to remove the pregnancy. Women are drinking blue Omo [detergent]. Women are drinking medicine for malaria to remove pregnancies. So if they knew there was an avenue [through which to have a safe abortion], I think those people would not be going up to that stage; it would have saved a lot of women by having an avenue for them to reach to the doctors who can help them. (Female, representative of Uganda Women Parliamentary Association, Kampala)

Some respondents spoke to the differential access that urban vs rural women have to safer abortion: while urban women can access an abortion by trained medical personnel in a good quality setting, rural women are more likely to go to untrained providers (traditional birth attendants or *sengas*, who are aunties who impart traditional knowledge) who perform abortions under unsafe conditions. Respondents stated that the illegality of abortion also results in fewer women getting needed PAC either because there are no formal avenues for providing follow-up care post-abortion or because women fear seeking treatment as they believe they will be prosecuted for procuring an illegal service.

Social consequences

Respondents spoke less frequently about social repercussions from restricting abortion, but when they did, they spoke to consequences for both women who have an abortion as well as to unwanted children that are born (see Table 2; answers do not sum to total sample size as often respondents gave answers which covered multiple themes). Women respondents were more likely than men to cite social ills resulting from restrictions on abortion access such as unsafe abortion creating widowers and unwanted children being born who no one cares for and no one pays to educate.

> These children [who were not aborted] will not go to school, because nobody will care for such a child. That's why we have so many [school] drop outs. A child goes to school, reaches P.4 [Primary Grade Four] and drops out because nobody cares, has no father, the mother can't afford. (Female, local government official, Bushenyi)

A few opinion-leaders, predominantly men, believed restrictions to abortion were positive because they reduced abortion and maternal mortality due to abortion. As Wibecan and Mato also found, this is due to the widely held belief that all abortion is dangerous, not allowing for the existence of safe abortion.

> It's good it [abortion] is restricted. There is nothing bad that comes out of someone being restricted from having an abortion. (Female, local government official, Lira)

Table 2 Perceived consequences of abortion restrictions on women, interviews with Ugandan opinion-leaders, 2009–10

Responses	*n*
Restrictions push women to use unsafe services	28
Women die due to abortion complications	8
Women experience health problems	6
Women and providers are legally prosecuted	4
Social problems including domestic violence and martial conflict occur	4
Restrictions protect people	4
Women don't access appropriate post-abortion care	3
It drives the price of abortion up	3
Current law deters women from having abortions	2

Perceived consequences of increasing access to safe abortion

Most respondents could identify benefits to increasing access to safe abortion while a smaller proportion, but still more than half, identified both positive and negative consequences of increasing access to safe abortion. Perceived benefits included increased health and economic welfare and less enacted social stigma at the individual level towards women having abortions. Perceived negative consequences included that abortion would be overused, individuals would forego preventative behaviour, and that it would lead to social chaos.

Benefits of increasing access to safe abortion

Over three-quarters of the respondents identified at least one benefit of access to safe abortion in Uganda. Male respondents were more likely to identify positive social and economic benefits to safe abortion than female respondents. Many perceived both positive and negative consequences from increased access to safe abortion. A small subset of respondents expressed that the only situation in which access to safe abortion would be positive was if the mother's health was at risk because of the pregnancy. Four respondents said there would be no positive effect of expanding access to safe abortions (Table 3).

The most commonly mentioned benefit of access to safe abortion, expressed predominantly by men, was fewer complications from unsafe abortion including fewer maternal deaths.

> Well, countries where the people have got safe abortion, they say the death rates are fewer. That's one thing I know from literature. As a scientist, now I talk as a scientist. The death rates from abortion are made fewer. (Male, Department Obstetrics and Gynecology at a large public hospital, Kampala)

Fewer deaths were also connected to the perceived consequence that safe abortion would allow women to care for and invest more in the children they already have. Economic benefits to safe abortion identified by respondents were that women would be able to continue their education or work.

> If they realize it is not a planned pregnancy and [safe] abortion is done, then the mother can do her other activities as usual with no worry of saying; 'I am going to get another child, how to take care of another child?' If it is really done in a safe way, then the mother and the family and the community as well, there is a way they would benefit. [...] So, still it would help the family to put those resources on those few ones [children] and really it would improve their standard of living. (Male, health officer, Bushenyi)

Respondents said that school girls who choose abortion could go back to school as they would not be suffering from complications and thus unable to return. A significant minority of respondents also identified that safe abortion access would reduce punishment or stigma towards women having abortions including abortion-related violence. The logic was that if abortion were provided in a doctor's office where many other types of health services were also provided, it would be easier to hide an abortion since it would not be clear what health services the woman had obtained.

> If someone has aborted and the community knew, because maybe she tried to abort from the village, and people knew of it, obviously where you try to abort from the village people will have to know. But if you went to the medical personnel in the hospital, like you are suffering from malaria, they will treat you, you go back home and people might not even notice that you had gone for abortion. (Male, development officer, Bushenyi)

One respondent observed that if women had access to safe abortion, they would not be in the hospitals with complications taking up resources that could then be invested in family planning. Another respondent spoke about the social benefit of slowed population growth.

Negative consequences of increasing access to safe abortion

Slightly more than half of the respondents, equally divided between male and female respondents, stated that access to safe abortion would have negative effects on behaviour and increase abortion incidence. The three main sentiments voiced by respondents with this perspective were: (1) safe abortion would be overused and abused; (2) there would be less focus on preventive behaviour (this idea was expressed more often by men than by women); and (3) increased access would create familial and societal chaos. The following respondents related the above themes to one another: abortion would be 'overused' as a result of a lack of preventative behaviour, leading to an unravelling of the social fabric.

> My fear is that a number of women whether young or old will have no restriction and will be saying, 'Even if I get pregnant, I will go and abort'. Because there will be many hospitals, many health centres, all health centres will be practising that, will be aborting.... So women will rush into that. My fear number two is that [...] chaos might erupt. (Male, district youth council, Bushenyi)

Table 3 Perceived consequences of increasing access to safe abortion, interviews with Ugandan opinion leaders, 2009–10

Responses	*n*
Fewer abortion-related complications	16
Fewer women would die due to pregnancy-related reasons	13
Pregnancy prevention would not be taken seriously	11
Greater economic well-being for her family and existing children	11
Women could more quickly return to their other responsibilities (child care, school, work)	10
It would reduce social stigma around abortion and reduce abortion-related violence	9
Women would avail themselves of abortion all the time	8
It would reduce health costs for the government	5
Women will use it instead of family planning; it will increase social chaos	4
It would slow population growth	2
It would lead to social chaos	2

> If the door is opened to safe abortion, even our kids won't study very well. Anytime will be abortion time. [...] The case of married women, even though it may promote health, it may lead to conflict between the husband and wife. [...] The man [may say], 'I can't feed you after you have aborted my kid.' You have shed his child's blood. (Female, local government official, Lira)

Revisions to the abortion law that opinion-leaders could support

Respondents were asked what they thought Ugandans and, if relevant, their constituents, would tolerate in terms of increased permissibility in the abortion law, although at times respondents conflated what they thought others would tolerate with their own opinions. Just under half of respondents stated that Ugandans would accept abortion in cases of rape, slightly broader grounds than is currently the law. While some respondents felt that more needed to be done to make abortion available on the grounds it is currently permitted, sympathy for the foetus was the primary reason that respondents were not in favour of greater access to safe abortion.

The most widely supported change to the abortion law in Uganda was in cases of rape. Yet this support was conditional upon the circumstances of the rape:

> I think abortion should be allowed both in the case of incest and in the case of rape. Because having somebody [a baby] [in those circumstances], it keeps on haunting. Somebody that was born in unclear circumstance is not wanted . . . I think it will be unfair, to be really hard and say no room for abortions. Because we are not all the same; and circumstances are not the same. In fact, many times I want to challenge those who say no, and say, 'What if it was your daughter gang raped by some guys who are HIV-positive, and you even test her and she is positive, and she gets pregnant, do you just blindly really encourage her to continue with that [pregnancy]' To me, I feel it's unfair. I would just terminate. First of all, we don't know who the father is, and we have found the daughter has now become HIV-positive, why should I continue with that pregnancy? Just terminate. (Male, community development officer, Kamuli)

As the above respondent indicated, abortion in cases of rape was perceived as more justifiable if the man responsible for the pregnancy was not known than if the rapist was known. The reason for this is as the following respondent explains: if the rapist can be identified, he can be forced to take responsibility and furthermore, the child would belong to a clan.

> If the child was raped and the rapist is known, normally, the rapist is caught and ordered to look after the pregnancy. But if it's a war and these soldiers camp around and start making girls pregnant, such [pregnancy] is condemned. [...] In many cases, abortion would be recommended because nobody would like to have a child without a father, unknown father, because here in Buganda, every child belongs to a clan. And if a child has no clan, the father isn't known, and then it would be difficult to give the child a name. (Male, minister, Buganda Kingdom)

Moderately strong support was expressed from just over a quarter of the respondents for abortion in cases of incest. Liberalization for cases of rape and incest was supported equally by men and women. Women were more likely than men to say that abortion is acceptable when the foetus is non-viable. A small number of respondents expressed that more needs to be done to actualize the law, which allows for abortion to preserve the life of the mother. One respondent said being HIV-positive should be a justifiable reason to abort. Respondents advocating for no exceptions for rape and incest mostly cited that the foetuses resulting from those situations were innocent and should not be 'punished' (Table 4).

There was very little support for abortion to be made available on demand in Uganda among the respondents; only 5 of the 41 respondents (three women and two men) supported abortion on demand (i.e. without making women give a reason they want the abortion):

> There should be a law to legalize abortion; otherwise, people will keep aborting secretly. If they say, let abortion be there and in a safe way, that can help. There should be health units [...] for aborting as there are now centres for family planning, there should also be centres for aborting. (Female, local government official, Bushenyi)

Just over a quarter of the respondents stated that there should be no changes made to the law.

Discussion

There was a broad acknowledgement among these opinion-leaders that the strict abortion law in Uganda resulted in negative health consequences for women, unwanted children being born and women dying. Yet in spite of this awareness, over half the sample did not support greater access to safe abortion. While some respondents could acknowledge benefits which accompany safe abortion such as that it would allow women to care for children they already have, many stated that if abortion were legal under broader criteria, women would abort often and without consideration. Abortion access in cases of rape when the rapist was unknown was the condition for which respondents expressed the most support.

Table 4 Abortion law that opinion-leaders would support, interviews with Ugandan opinion leaders, 2009–10

Responses	*n*
In cases of rape	17
When the foetus is non-viable	16
In cases of incest	13
No changes should be made to the law	12
For all reasons/on demand	5
Abortion should be allowed only if the mother's life is in danger	4
For students/young women	4

Respondents expressed concern that law liberalization would decrease preventative behaviour. Yet there is already little preventative behaviour occurring in Uganda. Only 26% of married women and 44% of unmarried women are currently using a modern method of contraception (Uganda Bureau of Statistics (UBOS) and ICF International Inc. 2012). The perception that increased access would lead to unchecked abortions exhibits a lack of trust of women's reproductive decision-making and does not account for the psychological experience of abortion for women and the social stigma associated with abortion in Uganda that prevents some women from accessing safer abortions today. While increased access to safe abortion was identified by the respondents as a way to reduce stigma associated with abortion, this argument was predicated on the assumption that increased access would allow women to hide abortion, not that it would normalize abortion.

Our findings are in line with Wibecan and Mato's (2009) on opinion-leaders' knowledge about unsafe abortion and reasons that were most likely to garner policy-makers' support: both studies found that our respondents were not informed about the actual law on abortion in Uganda and treated all abortion as unsafe, and that there was most support for abortion in cases of rape. However, we did find greater nuance than Wibecan and Mato on the issue of rape: we found that compassion for abortion in cases of rape was highest when the rapist was unknown. Our study goes further than Wibecan and Mato's on describing what policy-makers believe to be the consequences of unsafe abortion as well as policy-makers' perceptions of what would happen if there were to be increased access to abortion. Furthermore, by including ethnic leaders and conducting interviews in traditional languages at the district level, we have attempted to take into account the voices of traditional leaders as well as those who are not part of the English discourse on this matter. We believe these additional dimensions contribute to a fuller description of the policy context surrounding abortion in Uganda.

Limitations of this research include that respondents may have tried to provide answers they perceived to be socially desirable leading us to in fact misrepresent their beliefs. While we cannot speak of selection bias between respondents and non-respondents as such since this was a deliberate, qualitative sample, the respondents who were selected but who did not participate were only in Kampala and held high-level positions within the Ministry including the Deputy Speaker and the Minister of Health. We do not know how their opinions would have differed from those we were able to include in the sample but as we were able to secure interviews with less high-level individuals who are anti-abortion as well as others who held liberal attitudes towards abortion, we do not suspect that their non-response was due to specific attitudes they hold but rather due to their other time demands.

The fact that interviews were conducted in traditional languages and were translated into English by the interviewers means that there is room for error and inaccuracy to have been introduced by the field staff when translating the interviews into English. Another limitation is that because this project was seeking to explore attitudes of opinion leaders about abortion, we did not ask specifically about medication abortion. Lastly, when political offices change hands, opinion-leaders' attitudes may change as well. But since the President, who contributes greatly to the tenor of Parliament, remains the same and cultural leaders remain the same today as when we collected the data, it is unlikely that there have been major shifts in the political landscape on abortion attitudes.

If we are to look to other countries in the region to help us understand likely avenues for policy change, Ethiopia provides an instructive example. While there was organized opposition primarily from the religious institutions to the liberalization of the 2005 law, specifically the Ethiopia Orthodox Church and the Catholic Church, social and political conditions which facilitated abortion law reform in Ethiopia included lawmakers awareness that religion should not influence policy (Wolf 2008). Other facilitating conditions include a medical community sensitized to the consequences of unsafe abortion, widespread awareness of the ineffectiveness of limiting the incidence of abortion through legal prohibition, governmental support for international human rights conventions, and for reproductive health and population policies (Wolf 2008). These results point to differences between Ethiopia and Uganda and indicate ways that conditions could be fostered in Uganda to recreate the conditions in Ethiopia that facilitated law reform.

Conclusions

Unsafe abortion is demanding greater attention in the political arena due to international health benchmarks and treaties that Uganda has signed. The Millennium Development Goal #5 (MDG5) specifies a reduction in maternal mortality that cannot be achieved without addressing the contribution of unsafe abortion. Uganda's endorsement of the Maputo Protocol adds further political momentum to urgency to examine unsafe abortion (Special Session of The African Union Conference of Ministers of Health 2006).

The conflicting documents issued by the government on this topic make it difficult to know what the pre-eminent law is on abortion. Therefore, the Ministry of Health should clarify the law regarding pregnancy termination and carry out a public policy campaign to clarify the circumstances under which abortion is legal. Opinion-leaders, in particular, should be the targets of such a campaign as they are ill-informed and educating opinion-leaders on the subject holds the potential for the information being disseminated through their communication networks. Further information is also needed by opinion-leaders on the abortion rates before and after in other countries that have liberalized abortion to demonstrate that increased access does not result in greater use (Jewkes and Rees 2005; Suvedi *et al*. 2009). Finally, legislation to improve access to safe abortion that is most likely to gain support among opinion-leaders should be drafted and this legislation should be politically shepherded through the appropriate pathways to be ratified.

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Conflict of interest

None declared.

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