LIVED EXPERIENCES OF WOMEN WHO UNDERWENT INDUCED ABORTION:

A CASE STUDY OF RAKAI DISTRICT

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REG NO.2015-M271-10004

A RESEARCH REPORT SUBMITTED TO THE FACULTY OF HEALTH SCIENCES OF UGANDA MARTYRS UNIVERSITY IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF A MASTER'S OF PUBLIC

HEALTH-POPULATION AND REPRODUCTIVE HEALTH

OF UGANDA MARTYRS UNIVERSITY

AUGUST, 2017

DEDICATION

This report is dedicated to my beloved daughter Caitlin Crystal Immaculate M. Nantaba, for all the endurance that you have gone through given that I left you behind at a very tender age and a sensitive stage of your development. Deeply appreciated dear daughter

ACKNOWLEDGEMENT

First of all, I thank God Almighty for my life and success in my academics.

I also take this opportunity to appreciate Mr. Kasirye Jackson for financial and moral support , Aunt Nantaba Rovincer for the great care towards Caitlin, parents, brothers, sisters, relatives and friends.

I extend my sincere thanks to my supervisor Mr. Isaac Wonyima Okello without whose guidance and encouragement, this report would not have been submitted.

I want to extend my sincere appreciation to all the respondents from Rakai District who provided the primary data which informed the study.

I would also like to extent my appreciation to the in-charges of all health facilities in Rakai district and the District Health Officer Dr. Sakor Moses.

I want to thank all my lecturers who mentored me throughout this course; all your pieces of advice will be valuable to me throughout my career. May the Lord richly reward you all.

LIST OF ACCRONYMS

CRR	Centre for Reproductive Rights
DHS	Demographic and Health Survey
HIV	Human Immunodeficiency virus
IPA	Interpretive Phenomenological Analysis
MOH	Ministry of Health (Uganda)
PAC	Post-abortion Care
SRH	Sexual Reproductive Health
STIs	Sexually Transmitted Infections
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
WHO	World Health Organization

DEFINITIONS

Abortion: in this report this is defined as the termination of a pregnancy before the fetus has developed to a stage of more than 28 weeks/more than 500g or the deliberate intervention intended to end a pregnancy.

Abortion Rate: this has been defined as the number of abortions per 1,000 women all aged between 15-44 years or may be other specific group but within a given population

Abortion Ratio: this is the number of abortions per 1,000 live births within a given population.

Early Abortion: this is defined as an abortion that occurs before the end of 12^{th} week of the pregnancy.

Elective abortion: this will mean that the woman freely decides to terminate her fetus,

Late abortion: this will define an abortion that will have occurred after the end of the 12^{th} week of the pregnancy.

Medical abortion: this will define the abortions that would have occurred as an influence of the use of abortifacient medicines.

Spontaneous abortion: this will refer to non-induced embryonic or fetal death or passage of products of conception before 20^{th} week of gestation.

Surgical abortion: this will be defined as any procedure done on a woman with the intentions of terminating her pregnancy

Quality: "Doing the right thing the right way" as per the Ministry of Health of Uganda definition of quality is to be of consideration in this study.

Providers of Services: facilities providing the reproductive health and all health facility staff are to be considered under this regard.

Reproductive Health: This will be considered right from receipt, counseling, examination, evaluation and giving of treatment to the patients (clients)

Post-Abortion Care: This is part of sexual reproductive health services when a timely and high quality care provided to women who have just had abortion.

Threatened abortion: this refers to any vaginal bleeding before 28 weeks of pregnancy, without dilation of the cervix or expulsion of any Product of conception (POC).

Inevitable abortion: This kind of abortion results into vaginal bleeding and dilation of the cervix such that a viable pregnancy is unlikely even with no expulsion of POC.

Incomplete abortion: This abortion results into only expulsion of part of the products of conception before 28 weeks of gestation with continued painful contractions and bleeding.

Complete abortion: This kind of abortion results into expulsion of all of the products of conception before 28 weeks of gestation.

Induced abortion: The intentional termination of a pregnancy before the fetus can live independently.

Lived experience: used to describe the first-hand accounts and impressions of living as a member of a minority or oppressed group**.**

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ABSTRACT

Background: This study explored and described the lived experiences of women who underwent induced abortion in Rakai district. The study was carried out between August 2016 and August 2017.The guiding objectives were: to explore the lived experiences of women who had induced abortion in Rakai District on learning about the aborted pregnancy; to describe the lived experiences of the process of inducing an abortion among women who underwent induced abortion; and to explore the short and long term lived experiences after the induced abortion among women who had an induced abortion in Rakai district.

Methodology: A descriptive cross-sectional research design employing a phenomenological approach of qualitative study design was used. The population of interest for this study included only women who live in Rakai who underwent induced abortion. The researcher interviewed twenty-five women who had induced abortions in the past one to three years. Participants were selected purposively basing on the available records. The inclusion criterion was women who had an induced abortion in the last three years and were identified as residents of Rakai district were eligible to take part in the study, Women Aged 18-49, Post-Abortal of one to three years: Based on IPA. Data collection methods included screening interview, in-depth interviews and Tape recording. The researcher transcribed verbatim by playing the audio recordings and writing in a note book what was recorded.

Study findings: The key findings on the lived experiences included denial, shame, confusion, indecision, fear, anger, anxiety, depression and uncertainty. The participants reported use of local herbs among other substances to induce abortion. These herbs included: tea leaves, kisuula(Erlangea tomentosa), roots of sugar canes, ennanda(Commelinaceae). The processes involved were mostly traditional in nature and it was associated with: severe pain with heavy bleeding, washing the uterus, using assorted tablet, baby not coming out well. However, few used professional medics but a majority used local herbalists. The process was largely life threatening and horrible. The short and long term lived experiences after the induced abortion included secondary barrenness, depression, crying in privacy always, regret, hate for sexual relationships, emotional detachment from society and emotional maturity.

Recommendations: The study recommends that Health workers and women in child bearing age need to work together in a forum discussing openly how to control unplanned pregnancies; mothers should be given pre-natal counseling; School going children should be educated about contraception and be given real contraception; Women should induce abortion only after enough preparations; the legal fraternity should consider enacting laws; Women should stop shying away and seek for professional counseling; religious leaders and elders need to talk to women in a friendly and constructive way; parents need to talk to their daughters and provide guidance.

Further research needs to be done on how laws can be enhanced to protect women; need to find out how effective local medicine can be in the process of inducing abortions; the role of society in family cohesion and sexual relationship building needs to be streamlined.…….

CHAPTER ONE

INTRODUCTION

1.1 Introduction

This chapter gives an account of the background, the problem statement, research questions, study objectives and significance of the study.

1.2 Background

The term "abortion" is derived from the Latin word *aboriri*, meaning "to perish" (Henry, 1992). It entails both induced and spontaneous abortions. Induced abortion is a universal phenomenon occurring at all levels of societies where the products of conception are expelled before 28 weeks of gestation. The abortionists consist mainly of health worker's facilities, hospitals, health centers, dispensaries, ordinary bedrooms, and occasionally in a simple room. Induced abortion is either safe abortion or unsafe abortion (Neema, 2016). The process can be safe or unsafe. Safe termination of pregnancy is performed by skilled persons using appropriate tools in a sanitary environment. On the contrary, unsafe induced abortion is performed either by persons without the necessary skills or in an environment without the minimum medical standards, or both (WHO, 2011).

The World Health Organization (WHO, 2006) estimates that 46 million abortions are performed each year, 20 million of which occur in countries where abortion is punishable by law. One in three women will at least have an abortion in their lifetime (Henshaw, et al., 2008). Worldwide; women who seek to induce an abortion have different demographic characteristics. Levels of unintended pregnancies and unsafe abortions are higher among young unmarried women below twenty-five years of age in Africa than in any other regions of the world (Shah, et al., 2009).

It's estimated that one in three women will have an abortion during their lifetime (Henshaw, et al., 2008). Over 42 million abortions are estimated to be performed annually worldwide, and of which those carried out under safe conditions are 22 million. Worldwide, it's estimated that 21.9 million unsafe abortions are performed every year (WHO, 2011). Majority of the unsafe abortions are induced, where the women's lives are put at very serious risks during the procedures and the overall outcomes on their lifetime experiences (Singh, Wulf, Hussain,

Bankole, Sedgh, 2009). Of these unsafe abortions, 97% occur in low income countries. Out of these, 44% are recorded in Africa (Rasch, 2011). Induced abortions are performed globally (Biney, 2011). In Uganda however, induced abortion is illegal unless carried out on medical grounds. The Ministry of Health (MOH) estimates that maternal mortality due to abortion related causes was 26% in 2011 (MOH, 2012), a rate which is considerably higher than that reported in the Eastern African sub-region (13%).

The reason for performing induced abortion varies from health related issues to cultural norms and is subjective to the victims. These include among others: rape, defilement, poverty, and failure to use contraception (Biddlecom et al, 2008). Some perform it due to unintended pregnancies or as a birth control method (Bogart's &Westoff, 2000). Some women use induced abortion as a tool to regulate menstruation, others to terminate teenage pregnancies, while to others do it with the desire to continue with education (Biney, 2011). However, the reasons given for having an induced abortion in surveys are often superficial. There may be many reasons why women induce abortion and the problem is persistently on the rise globally with undesirable outcomes (WHO, 2012). Studies by Upadhyay, Brown, Sokoloff et al., (2012); Roberts, Silva, Xu (2010) done from a variety of countries (both developed and developing) such as India, Nepal and New Zealand indicate a range of perceptions toward induced abortion.

Two recent studies by public health researchers (Kassebaum, Bertozzi-Villa, Coggeshall et al, 2014; Say, Chou, Gemmill et al, 2014) indicated that globally by 2014, induced abortions accounted for 8%-18% of maternal deaths. An earlier study by Singh (2006) indicated that millions more women suffer non-fatal health consequences of induced abortion every year.

Elective abortion is one of the most passionately debated issues in local, national, and international politics and within religious communities. A large body of scientific literature has been devoted to the psychological experiences of women who undergo elective abortion procedures (Bradshaw & Slade, 2003; Steinberg, 2011). Although the rhetoric surrounding abortion remains highly politicized, the large preponderance of the literature indicates that 2 abortion does not cause psychological problems, and that some women interpret their abortion as a positive life-changing experience The pre-abortion period is associated various states of lived experiences which include psychological, social and personal in nature. These manifest as mental

health problems like negative attitudes towards abortion, lack of social support and conflict with an intimate partner. There is thus need for coping strategies to ensure good sociocultural and psychological health outcomes following an abortion procedure (Alanson, 2007).

Keogh, Kimaro and Muganyizi (2015) indicated that in the East African region alone, an estimated 613,000 women were hospitalized due to induced abortion related complications (Singh, 2006). Keogh et al. (2015) further noted that today many more women suffer complications but do not access care. In Uganda, health indicators are still poor. The total fertility rate stands at 6.2 children per woman (UBOS, et al., 2012). The maternal mortality ratio is 310 per 100,000 live births. Abortion related deaths contribute 26% to this maternal death (WHO, 2012).

Therefore, almost all countries have laws prohibiting the execution of an induced abortion unless when it's under the acceptable circumstances of the law. Likewise, Uganda has laws that prohibit and permit induced abortion under certain conditions. Abortion in Uganda is illegal unless performed by a doctor who believes pregnancy places the woman's life at risk. The legal status of abortion in Uganda is unclear because it provides for some exceptions while criminalizing the procedure in most cases. The Ugandan Constitution, in Article 22, item 2 states: "No person has the right to terminate the life of an unborn child except as may be authorised by law (Constitution of the Republic of Uganda, 1995). However, what is authorized by law remains poorly understood. However, these laws and policies are not precise enough and they are always interpreted incoherently. This then brings a challenge of hardship to the women and the medical community to comprehend what is legally allowed (CRR, 2011). The result of this is refusal of the medical providers to perform or induce an abortion for fear of the consequences. This can then call for the use of unsafe abortion procedures.

Unwanted pregnancies are on the rise, with 1.4 million pregnancies occurring in Uganda (Khan, et al., 2008). This increasing numbers of unwanted pregnancies in Uganda play a very big role on the increasing numbers of unsafe abortions which constitute almost one third of maternal deaths with the country's young people (Singh, Prada, Mirembe & Kiggundu, 2005; Nalwadda, et al., 2005). This has led to increased hard life experiences that are experienced by the victims. This greatly raises the need for this study on the lived experiences of women who underwent induced abortion in Rakai District.

1.2 Problem Statement

Nearly half of the estimated annual 1.4 million pregnancies that occur in Uganda are unwanted (Khan, et al., 2008). Majority of these unplanned unwanted pregnancies are strongly associated with the high numbers of unsafe abortions in the country (Nalwadda, et al., 2005). An estimated 297,000 illegal abortions are performed annually in Uganda (Singh, et al., 2005) and limited literature is available either on the lived experiences of these women in deciding to undertake induced abortion, or their experiences during the process of inducing the abortion. This is occurring amidst rising global burden of induced abortion (Warriner & Shah, 2006). It is important to study the experiences of women who had induced abortions in Rakai District first of all, since all studies did have focus on the analysis of effects of abortion and few have been done in Uganda with methodological difficulties. Secondly, the problem of induced abortion is on the rise due to high level of teenage pregnancies in Rakai (Rakai Health Sciences Program, 2010). These are thought to be unwanted thus leading to induced abortions. Lack of research is likely to perpetuate serious consequences on women in reproductive years.

Among the long term problems of not researching this phenomenon is that there has been a renewed political and lobbying interest on the question of abortion worldwide and in Uganda particularly. It is unclear where this interest leads but this calls for research to provide evidence and recommendations for guiding future researchers and practitioners (health workers). Once this is not done, there could be continuous dilemmas encountered in future studies and policy making on reproductive health. The studies done elsewhere may not be fully appropriate to inform the current Uganda social-economic and political setup. Developing a scholarly understanding of women's lived experiences of induced abortion in Rakai district will generate important local information on the lived experiences of women who underwent induced abortion in Rakai District and allow for creation of appropriate policy interventions about the causes and effects of induced abortions from a more practical perspective.

1.3 Study Objectives

1.3.1 General Objective

To explore ascertain the lived experiences of women who underwent induced abortion in Rakai district.

1.3.2 Specific Objectives

1. To explore the pre-abortion lived experiences of women who had induced abortion in Rakai District on learning about the aborted pregnancy.
2. To describe the lived experiences of the process of inducing an abortion among women who underwent induced abortion in Rakai District
3. To ascertain the short or long term lived experiences after the induced abortion among women who had an induced abortion in Rakai district.

1.4 Research Questions

1. What are the pre-abortion lived experiences of women who had induced abortion in Rakai District on learning about the aborted pregnancy?
2. What are the lived experiences on process of the induced abortion among women who underwent induced abortion in Rakai District?
3. What are the short and long-term lived experiences after the induced abortion among women who had an induced abortion in Rakai district?

1.5 The Conceptual Framework

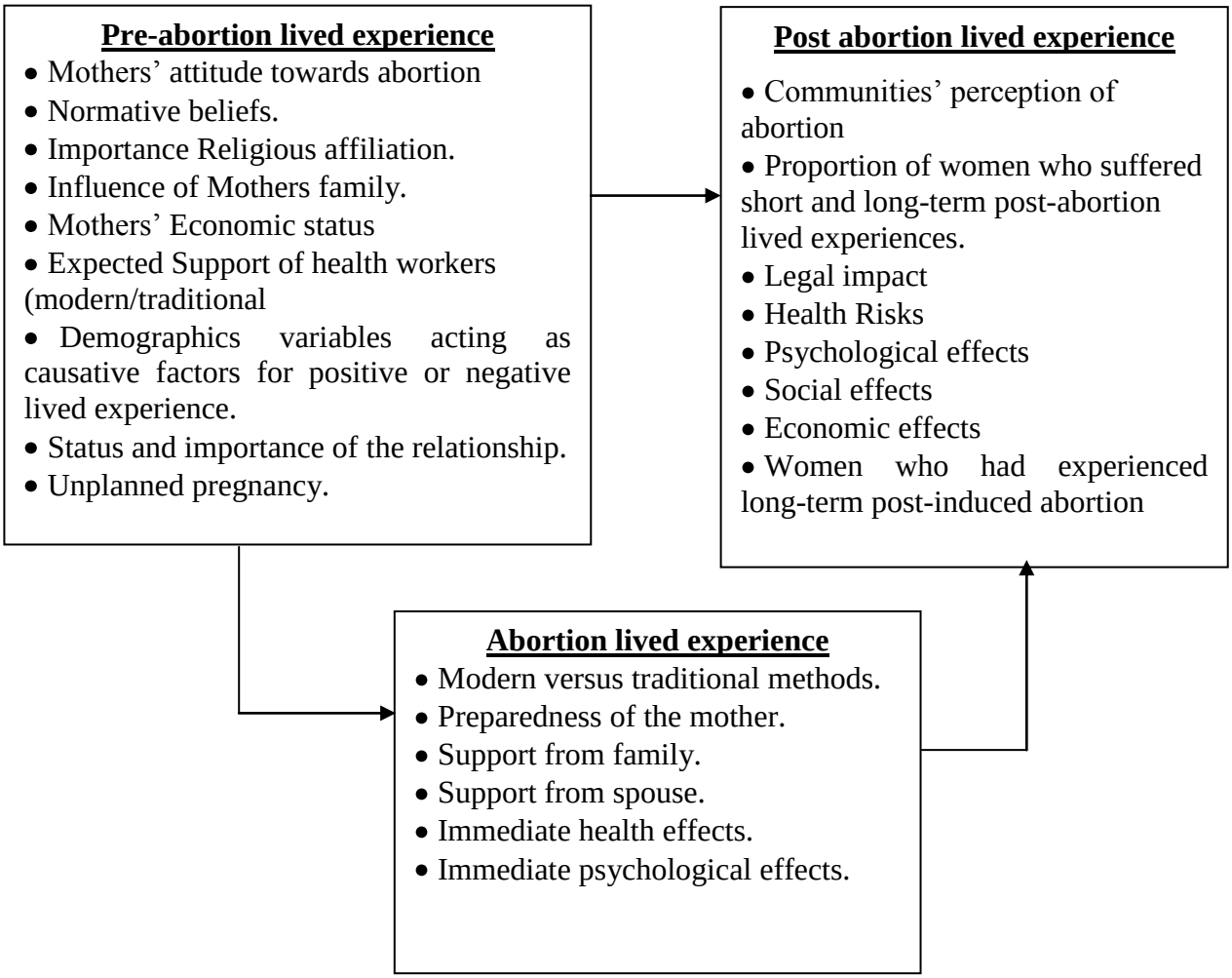

Figure 1: The conceptual framework

Source: Adopted and modified from the Theory of Reasoned Action (Ajzen &Fishbein, 1980)

Explanation of the conceptual framework

The reasons for having sex can be for pleasure, to fulfill sexual desire or as a result of coercion. After conception, the subjective norms such as: pressure from the couple to abort or lose a relationship, fear of the parent, the timing of pregnancy as for married couples may arise. When the woman reasons within herself and finds no other alternative, she will make informed

decisions on induced abortion. The reasoned informed decision then forces the woman to go and have induced abortion. The place of conducting this induced abortion is subject to the ability of the woman to afford the cost of the procedure irrespective of its consequences.

The process of performing the procedure and the effects of performing induced abortion is known to affect the behavior of the victim (mother). These effects are both short and long term in nature but are non-forgettable. This behavior affects the holistic life of a mother and it's what constitutes lived experience of women who underwent induced abortion.

1.6 Scope of the Study

The study explored the lived experiences of women who underwent induced abortion in Rakai district. The choice of Rakai district was due to high induced abortions. For instance, in a study done by Singh, Guttmacher Institute; Prada, Mirembe and Kiggundu (2005), respondents came from eight districts: Kampala, Mukono, Mpigi, Wakiso, Iganga, Jinja, Ssembabule and Rakai. In Singh (2005), the Ministry of Health sampling frame contained a total of 96 hospitals, 163 health centers level IV and 787 health centers level III. The reporting in this study was generalized and thus the need to specify scores for each area and focus was not on rate of abortion but on share of care to mothers who aborted in the different health facilities. Singh (2005) concluded that Public-sector facilities provided care to about 60% of postabortion patients, while private facilities serve the remainder

The current study focused on the lived experiences of women who had induced abortion in Rakai District on learning about the aborted pregnancy; secondly the lived experiences on process of the induced abortion among women who underwent induced abortion in Rakai District. Finally, it focused on the short and long-term lived experiences after the induced abortion among women who had an induced abortion in Rakai district.

1.8 Significance of the Study

Induced abortion in Uganda is stigmatized in many various social, cultural and religious communities and many of the women have reported negative attitudes towards abortion, there is thus a corresponding need to increase our understanding of women's challenges and reactions to this experience. This will enable both policy makers and practioners to help women better.

This research will help leaders in societies to appreciate personal and environmental circumstances that are associated with post-abortion well-being to improve the likelihood that women who get an abortion have the best possible outcomes in their lives.
This study will create a new reference literature which is vital to students, researchers and the entire globe who will wish to carry out more similar or related studies.

The findings of this study if used would enable health practitioners to design strategies for care targeting women who underwent induced abortion especially about care and the social impact on the holistic life itself. This might lead to the development of abstracts of what had not been previously investigated on lived experiences of women who underwent induced abortion in Rakai district.

Given the high prevailing occurrences of induced abortion globally (WHO, 2012). Health practitioners may use the findings of this study to provide care and learn lessons on what caused the women to undergo induced abortion and how to care for them and its associated effects as well.

Health educators may use the information generated from this study to improve and package the information to women on lived experiences of induced abortion and how service delivery can be improved to manage the aftermath effects of induced abortion such as sadness, post-traumatic stress disorders (PTSD) and sepsis among the women who had induced abortion.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter contains evidence based studies on as per the specific objectives, the researcher acknowledges the various authors whose works are cited in this research proposal and further highlights the known lived experiences after induced abortion and the gap that needs to be filled.

2.2 Brief historical approaches of abortion

Motivated by a deeply held compassion for the women and children whose homes she visited around the world, Sanger believed that,

> [*universal access to birth control would reduce the need for abortion — a common and dangerous method of family planning in her time. _ Save women's and children's lives; _ strengthen the family; lift families out of poverty; increase the good health and well-being of all individuals, families, and their communities; and _ help women gain their legal and civil rights. Sanger's efforts made it legal to publish and distribute information about sex, sexuality, and birth control_ created access to birth control for poor, minority, and immigrant women spearheaded the development of contemporary safe, effective, and affordable oral birth control pills and other hormonal methods* (Chesler, 1992, 22, 39).]

Sanger turned women seeking abortions away from her clinics: "I do not approve of abortion." She called it "sordid," "abhorrent," "terrible," "barbaric," a "horror. Sanger called the results of abortion "an outrageous slaughter," "infanticide," "foeticide," and "the killing of babies. That birth control "has nothing to do with abortion, it has nothing to do with interfering with or disturbing life after conception has taken place." Birth control stands alone: "It is the first, last, and final step we all are to take to have real human emancipation (Sanger, 1920).

Mercury was used for inducing abortion over 5000 years ago (Glenc, 1957). It can be further traced around 1967, when the World Assembly embarked on its aftermath and recognized it as a dangerous public health concern. Further researches that are much remembered and recognized began in 1987 by Surgeon General C. Everett Koop who was tasked by the then President of the

United States of America, Ronald Reagan to produce a report on the overall life time health effects of abortion. The report acknowledged that induced abortion is safe when done under ideal medical conditions and the reverse is true, however there was insufficient evidence detailing the psychological effects of abortion (Koop, 1987). The report triggered a number of scientific studies to show lived experiences of women after abortion. Following several of these discussions, the WHO developed protocols and guidelines specifically for the management of unsafe abortions.

By 1967, the World Assembly recognized abortion as a serious health problem, but about thirty years down the lane, not much was achieved in terms of solutions.

2.3 Pre-abortion Lived experiences of women who had induced abortion on learning about the aborted pregnancy

Steinberg and Finer (2011) postulated that because the (supposed) deleterious psychological effects of having an abortion are frequently cited in policy-making contexts as rationale for limiting access to abortion, psychological theories of abortion and the literature on both positive and negative psychological correlates of abortion are presented. This section concludes with an overview of potential mediators and moderators that help illustrate the complexity and often idiosyncratic nature of the abortion experience.

It is further argued that lived experiences of abortion are a hotly contested issue that has led scholars and activists on both sides of the debate to publicly state the importance of removing political and religious bias in order to pursue rigorous scientific studies that can shed light on the real psychosocial impact of abortion. However, both sides of the debate also continue to accuse the other side of misinterpreting or misrepresenting data (Steinberg & Finer, 2012). This was in response to the Coleman, Coyle, Shuping, & Rue, 2009) quantitative review of the abortion lived outcomes literature.

Even if the literature were to suggest that induced abortion is related to poor psychological health, the evidence must be considered in light of the alternatives to abortion once a woman unintentionally becomes pregnant, a comparison which is methodologically difficult. Some studies indicate that a woman's pre-abortion mental health status is one of the most important

predictors of poor outcomes following an abortion (Major et al., 2000; Steinberg & Finer, 2011). In a two-year longitudinal study of 442 women who had an elective abortion, a pre-abortion history of depression was strongly associated with post-abortion depression, low self-esteem and negative abortion outcomes (i.e., more negative emotions, less satisfaction with the abortion decision, more harm and less benefit, and symptoms of PTSD; Major et al., 2000).

On the other hand, Steinberg and Russo (2008) explored the relationship between abortion and anxiety in two studies, finding that among 3,981 women in the National Family Growth Survey who reported that their first pregnancy was unintended; women who abort the pregnancy have higher rates of anxiety symptoms than women who carry the pregnancy to term. However, after pre-pregnancy anxiety symptoms, experience of rape, and other potentially confounding demographic variables (marital status, poverty status, educational level, and race/ethnicity) were controlled, the relationship was no longer significant. Specifically, the best predictor of post-pregnancy anxiety was the presence of pre-pregnancy anxiety. It may be that pre-abortion mental illness serves to weaken a woman's ability to cope with a variety of life stressors, including abortion, perhaps leading women with mental illness to interpret the abortion decision more negatively and to in turn respond with more negative emotions including sadness, anxiety, or regret.

Another recent study in Texas by Fuentes, Lebenkoff and White (2016) conducted 23 in-depth interviews and performed a thematic analysis. Fuentes et al. (2016) report confusion about where to go for abortion services, increased cost and travel time as well as compromised their privacy. In the same study by Fuentes et al.(2016), women described being uncomfortable, lonely and feeling sick while traveling far from home.

> *["We didn't know how long it was going to take, 'cause we can drive 4 h over there, do the procedure and then drive 4 h back, but we didn't know how I was going feel…we didn't want to be on the road and then I start — I keep bleeding… you know?…before you could just go to McAllen. It wasn't so far away, and you could come back to your home and be comfortable…but having to go all the way there and not even feel comfortable, not even be where you're naturally from and being in a hotel afterwards…that's the only experience I didn't like, the whole traveling and then having to stay somewhere we didn't want to stay, but since we lived so far away that we didn't have a choice."* (p.8)]

From the above extract, Fuentes et al. (2016) illustrate the challenges women normally experience in their attempts to abort.

It has been suggested in previous research that several restrictions prevent women from obtaining abortions, especially where services are obtained from a distant facility (Grossman, Baum, Fuentes, 2014; Colman and Joyce, 2011; Dennis, Henshaw, Joyce et al, 2009; Joyce, Henshaw, Dennis et al, 2009). Sell and Kotzias et al. (2015) carried out a research to find out what motivates women to induce an abortion, stated otherwise, the lived experiences before abortion. Results show that the illegality of abortion is identified as a risk factor for unsafe abortions, reaffirming this issue as a public health and social justice problem. Sell et al. (2015) show how health workers are sharply divided on whether or not to accept inducing an abortion and this dictates whether or not mothers will do a safe abortion under the care of a professional or an unsafe abortion without professional intervention which again cause worse results afterwards.

Welter (2015) shows how culture and religion among young Mexican-American women played an important role in the decision-making processes relating to abortion. Results indicated that abortion was unique and more difficult for Mexican-American women, given cultural and religious norms that specifically prohibit abortion and simultaneously prioritize sexual purity, responsibility and motherhood for women.

Welter further noted that it is clear from her findings/data that during their lifetime, many women will experience an unplanned and or unwanted pregnancy that invariably leads to a reproductive decision-making tree that may include abortion. However, some researchers have noted that women should be informed that there are no proven associations between induced abortion and subsequent ectopic pregnancy, placenta praevia or infertility (Gan, Zou , Wu , Li, 2008).

Welter (2015) also noted that the way a woman interprets her induced abortion decision is related to her emotions and well-being following an abortion procedure. Studies suggest that more positive emotions towards the pregnancy and unborn child (for example “wantedness” of the child; Miller et al., 1998), higher levels of ambivalence about the abortion decision (Miller et al., 1998), more complexity in the abortion decision (Allanson, 2007), and feelings of guilt

versus anger (Cozzarelli, Major, Karrasch & Fuegen, 2000) increase the likelihood of negative psychological outcomes following an abortion.

A prospective study explored mediators and moderators of the psychological outcomes of abortion enrolled 145 women who had volunteered for a medical abortion procedure that was being offered for the first time in the US (utilizing mifepristone administered with the prostaglandin misoprostol during the first five weeks of pregnancy in the St. Louis area in 1995; Miller et al., 1998). Women were interviewed at three time points, immediately before the medication administration, two weeks post-abortion, and 6-8 months post-abortion. Results demonstrated that higher levels of *wantedness* of the child predicted acute stress, regret, and relationship dissatisfaction 6-8 months following abortion. The current study has similarities with Miller et al. (1998) as most mothers revealed that they were not happy with their decisions and largely regretted the act of abortion.

Regarding decision making to undergo induced abortions, studies have shown mixed results especially from North America and South America. Research consistently indicates that most women seek induced abortions because their pregnancies were unplanned and a variety of overlapping psychosocial reasons limit their ability to be good mothers at the time of pregnancy (Finer, Frohwirth, Dauphinee, Singh, & Moore, 2005).

Finer et al. (2005) explored induced abortion decision-making among 1,209 women at 11 large U.S. abortion clinics. All women completed a short survey about the reasons for their abortion and 38 women also participated in a semi-structured interview to explore their rationale in more detail. This study shows that the reasons most frequently cited were education, work or ability to care for dependents (74%); affordability (73%); relationship problems (48%) (Finer et al., 2005, pg. 110)

The authors (Finer et al., 2005) also focused their discussion primarily on the theme of *responsibility*. Specifically, authors noted that while women who seek induced abortions have been portrayed as irresponsible and immoral in media and politics (Russo, 2008), the women in this (Finer et al., 2005) and similar studies made intentional decisions by considering a multitude of factors, including the morality of an abortion and the morality of giving birth to a child that

could not be appropriately cared for, in order to arrive at a decision that would best serve the current and future economic and psychological needs of their families.

Similarly, the ways that moral and ethical issues are central in many women's abortion decision-making processes was illustrated in another recent study. Eighty Norwegian women were followed for two years post abortion and asked to report on a variety of feelings about the abortion. Consistent with other studies demonstrating that women take ethical issues into consideration when making this serious life decision, the most strongly endorsed feeling ten days, six months, and two years following abortion was "doing right" (Broen, et al., 2005).

Regarding coping with the lived experiences, personal coping strategies are also related to more or less positive outcomes following an abortion. Although results are complicated, the Allanson (2007)' prospective study indicates that coping with stress through positive thinking was related to more positive abortion outcomes in the long-term, while avoidance of distressing emotions was more predictive of negative outcomes. In the Alanson's study, coping strategy varied by abortion decision-making rationale.

According to, Sell et al. (2015), there has been disagreement on what actually motivates induced abortion. Most studies cite rejection of pregnancy itself; abortion is taken as a contraceptive method; limited access to family planning services. Other factors include; socioeconomic factors like unemployment or fear of losing their jobs; fear of the reaction of parents or disappointing them; domestic violence including sexual, physical and psychological coercion perpetrated by intimate partners and family. The issue of relationship complexities and the desire to remain in school also come out strongly as motivating factors. The current study reveals women having complicated relationships with husbands, desire to continue in school, need to protect their jobs, cheating in marriage and getting pregnant outside marriage, poverty and limited livelihood to support both the mother and baby as outstanding factors predicting abortion among mothers in Rakai.

Nader, Blandino and Maciel (2007) in their study in Brazil show that most women who had induced abortion had unplanned pregnancy. Initially, some expressed the desire to keep their pregnancies, only to be let down by pressures imposed by the situation thus inducing abortion

against their will. From the University of São Paulo (USP), Mariutti and Furegato (2010) carried out a study where it was indicated that the difficulty of coping with both the pregnancy and having induced an abortion can affect the mental health of women. There other effects which come along with induced abortion which includes anxiety and depression.

Other researchers (Silva & Vieira, 2009) have posited that the lack of access to contraceptive methods contribute to the increase of these pregnancies and consequently to the increase of abortions in unsafe conditions. According to Nader et al. (2007), the decision to abort, often encouraged by the partner, shows that there was no planning for the pregnancy. Souza and Diniz (2011) brings a case where Latin American and African society view induced abortion as a moral hazard, a result of having unreliable partners, financial instability, premature age and a dishonor and shame to the family of the woman involved.

Ertelt (2010) attributes abortion to drug abuse as women from Canada were studied and it was found out that those who abused drugs were four times more likely induce abortions. It can thus be inferred that there is a link between abortion and the substance abuse issues. Women having abortions were 3.8 times more likely to have substance abuse disorders. Ertelt (2010) noted that this was the case even when other factors such as exposure to violence were included that could have raised the risk outside of abortion. Ertelt (2010) also shows that abortion was associated with mood disorders, although substance abuse proved to be the strongest influencing factor.

A Malaysian qualitative study by Tong et al. (2012) looked at the experiences of women and their needs with regard to abortion. The researchers aimed at understanding by uncovering values, the meaning behind the experiences of women who have had an induced abortion as well as their needs with regard to abortion. They revealed that women were afraid of the side effects of induced abortion and sought for more information about abortion. More so, findings revealed that women had mixed post-abortion feelings ranging from no feelings to not wanting to think about the abortion, relief, feeling of sadness and loss.

Reardon and Coleman (2006) found that, women who experienced abortion had need for being treated for sleep disorders or disturbances compared to women who gave birth. Yet another random study done in early 1990 by Barnard (1990) (cited in Elliot Institute Report 2009) found

that a minimum of 19% of post-abortion women in developed countries of USA and Canada suffered from diagnosable Post-Traumatic Stress Disorder (PTSD). The study also reported that roughly half had many, but not all, symptoms of PTSD, and 20-40% showed moderate to high levels of stress and avoidance behavior relative to their abortion experiences.

A Ghananian study by Appiah-Agyekum (2014) explored some of the key experiences of University students on abortion in Ghana to provide information for evidence based interventions. Data was collected from 142 students of the University of Ghana through 18 Focus Group Discussions FGDs. Results indicated that majority of the abortions were self-induced and done in the first trimester of the pregnancy. Only 9.8% of students used safe abortion services despite being aware and having access to them. Specifically, his qualitative results from FGDs show that all students involved in the study had experienced abortions with 66.9% having personal experiences on abortions. Students in this group were females who had undergone an abortion procedure or males had consented to, influenced or supported a partner to have an abortion. Also, 26.1% had direct experience from peers - friends, course-mates, roommates. Students in this category were those who though had not personally had an abortion, closely knew or assisted a peer to undergo an abortion. The remaining 7% had experienced abortions in their family especially with their sisters.

Vilma (2006) in his academic thesis investigated and described how women create meaning about their experiences of first abortion. The thesis was aimed at understanding how women view their abortion experiences looking back (retrospectively), it also analyzed how they reconstruct their meaning after undergoing personal, psychological and emotional events changes. Vilma argued that women's retrospective understandings of abortion are not static and unchanging and these meanings are not the same for all women. In his study findings, 4 main themes emerged among respondents: struggling to find meaning of abortion for self and for life, coping with emotional subsequences, keeping on being who I was or perceiving life, and wishing emotional support from family and friends. The result of the study showed that most of women experienced negative feelings in respect to post-induced abortion after learning about aborted pregnancies.

Majority of unwanted pregnancies begin as unplanned pregnancies. However, sometimes even the planned pregnancy may end up into being unwanted pregnancy with the major outcome worldwide being induced abortion (Baginsk, 2007). Accordingly, Jones & Jerman, (2014) noted that women do not suffer severe and long-lasting emotional trauma such as "post-abortion trauma," "post-abortion syndrome," or "post-abortion survivor syndrome as a result of induced abortion. They have called this nonexistent phenomenon but propaganda by antifamily planning group. They further argued that neither the American Psychological Association nor the American Psychiatric Association (APA) recognizes the existence of post induced abortion phenomena or syndrome or post-traumatic stress disorder, and that there is no substantive scientific evidence that those effects are true. On the other hand, the anti-abortion campaigners argue that there are a number of side effects of induced abortion (AMRC, 2011).

Despite the cultural and social relevance of child bearing in many African communities, unwanted pregnancies are always the source of problems in many families. This is worse for young girls who often fall pregnant outside marriage. The usual easiest and best option for them is to terminate the pregnancy regardless of the complications just to avoid facing the judgment from their families, friends and the community as a whole (Neema, 2012)

One of the experiences women who induced abortion commonly get after realizing that they were pregnant is emotional disturbances. In a study carried out by Kidist, (2015), participants reported that they got serious emotional disturbances immediately they realized that they were pregnant. They experienced episodes of distress, discomfort, shame, sadness, guilt, and fatigue of being in dilemma to terminate the pregnancy or having a baby. Further still, the majority of single unmarried participants experienced different negative emotional upsets because of their financial constraints plus the unending fear of the influence of the people around them. Further still, despite the majority conceiving within a committed relationship, they clearly saw the pregnancy as burden and solely their responsibility. To them pregnancy outside marriage is not acceptable.

Abortion remains a secret affair and this obscures statistical accuracy about how prevalent the acts of induced abortion are (Elliot Institute Report 2009). This accounts for why studies done in several parts of the world seem to provide divergent results for instance in Asia, Latin America

and North America (Canada and USA). In countries like Uganda with diverse socio-demographic contexts, where cultures change in each geographical area, it is difficult to come up with conclusive results. However, the fact remains that abortion is existent and in worrying trends and thus action has to be done to prevent factors that finally culminate into induced abortion.

The issue of whether education levels influence induced abortion and in which direction needs to be factored in to determine to if the increase in the cultural level might be favoring the awareness of women's autonomy, or if education is advancing a dissociation from health care and reproductive planning, considering that abortion still causes maternal deaths (Akinrinola, Susheela & Taylor,1999). The lived experiences of women, who are the victims of unwanted pregnancies, highlights the lack of conditions in which they have to exercise free choices and decisions. On the other hand, literature above shows that criminalization does not deter the occurrence and only reinforces the conditions of risk (Akinrinola, Susheela & Taylor, 1999).

Despite significant rhetoric about abortion in politics, religion, and the general public, there is little emphasis on understanding the actual lived experiences of women who ultimately choose or decide to have an abortion. Discussion focuses instead primarily on the morality of the choice, the value of the child's life versus the mother's, lived experiences of women who had induced abortions, or the appropriate role of the health sector in determining women's reproductive health decisions, amongst others.

Welter (2015) notes that, the decision to have an abortion is inherently personal and unique for each woman who is to undergoing it. Thus, seeking to understand average "psychological effects" therefore obscures the power and complexity of this decision for the women who make it. Qualitative research that contextualizes the abortion decision, seeking to make sense of the life experiences and decision-making processes of women who ultimately elect abortion can move the literature beyond the rhetoric of the "abortion outcomes" debate towards helping women and families make the best possible reproductive decisions based on their unique values and life circumstances.

In the above literature, authors seem to appreciate that abortion is real and needs to be controlled. However, limited emphasis is put on the discussion of what exactly women undergo through in the period shortly before making the decision to abort. A clear understanding of this can be very insightful to policy makers to design relevant preventive customized interventions.

2.4 Lived Experiences of the Process of Inducing an Abortion among Women who Underwent Induced Abortion

The question of what type of emotions women experience is not answered despite documented research efforts over the past 30 years (Royal College of Psychiatrists, 2008). Below is some recent literature on positive and negative experiences of the induction process among women who underwent induced abortion.

2.4.1 Positive Experiences of abortion

According to Fergusson, Horwood and Boden (2009), abortion brings along positive and negative emotional reactions. It has been reported that risks of subsequent mental health problems increase with the extent of the negative emotional reactions after induced abortion. As part of the assessment at age 30 years, women who had had an induced abortion were questioned about their reactions to abortion (Fergusson et al, 2009). Abortion has been associated with high rates of both positive and negative emotional reactions; however, nearly 90% of respondents believed that the abortion was the right decision (Fergusson et al, 2009: p.420). The researchers found out that Women who had experienced more than one abortion were asked to respond about their reactions to their first abortion. They explained that the high frequency of negative reactions was offset by a number of positive reactions, including: relief, happiness, and satisfaction. Over 86% of women reported at least one positive reaction, with 29.8% reporting all three reactions. In terms of definite reactions, 59.6% reported one or more definite reactions, with 12.5% reporting three definite positive reactions. In the current study only 3 women out of 25 studied indicated an overall positive outcome of abortion (12%).

A follow up study (Bellieni & Buonocore, 2013) critiqued some researchers investigating post-abortion reactions report only one positive emotion: relief. Bellieni and Buonocore (2013) note

that, the relief felt by women after an induced abortion is only temporary. This is followed by a period psychiatrists identify as emotional paralysis or post-abortion numbness.

A recent longitudinal study by Rocca, Kimport, Roberts, Gould, Neuhaus and Foster (2015) investigated decision rightness and emotional responses to abortion in the United States. Rocca et al., (2015) examined women's emotions and reports of whether the abortion decision was the right one for them over the three years after having an induced abortion. Findings in their study indicate that the predicted probability of reporting that induced abortion was the right decision was over 99% at all-time points in the study period. Furthermore, they found out those women with more planned pregnancies and who had more difficulty deciding to terminate the pregnancy had lower odds of reporting the abortion was the right decision. They indicated that positive emotions declined over time, with no differences between women having procedures near gestational age limits versus first-trimester abortions. These positive experiences that women in this study reported over time included: maturity, deeper self-knowledge, and strengthened self-esteem.

Bradshaw and Slade (2009) reported about the effects of induced abortion on emotional experiences and relationships. Most of his literature reviewed showed that women due to have an abortion are more anxious and distressed than other pregnant women or women whose pregnancy is threatened by miscarriage. They however noted that in the long term they do no worse psychologically than women who give birth. He noted that self-esteem appears unaffected by the process. The critical literature shows that limited research has considered impact on the quality of relationships and sexual functioning, but in Bradshaw and Slade (2009)'s study, such negative effects were reported by up to 20% of women.

A study conducted in Maharashtra and Rajasthan by Melkamu (2011) on Comprehensive Abortion Care shows that most of the quality dimensions have a positive impact and the predictors. These were provider behavior, assurance regarding follow-up, medical information and waiting time in obtaining services, background factors, is residence. Another study conducted by Kitila (2016) showed that most of the quality dimensions were positive and the predictors were; provider behavior after induced abortion, assurance regarding follow-up of

services, medical information and waiting time in obtaining services, background factors and residence.

An earlier study was conducted by Ghosh, Acharya, Kalyanwala and Jejeebhoy (2008) in Mexico City where the Six domains of quality of care, namely; client-staff interaction, information provision, technical competence, post abortion contraceptive, accessibility and facility environment, were assessed. Their findings indicated respectfulness, protecting privacy, sufficiency of information, good technical skill, convenience of working hours , waiting time and cleanliness of the facility were associated with higher overall scores.

Norris, Harrington, Grossman et al., (2016) indicate that women in Zanzibar terminate pregnancies in a situation of multiple uncertainties. The authors cited a paper by Center for Reproductive Rights (2012) which stated that while some legal exceptions exist for abortion in Tanzania, a Center for Reproductive Rights report states that Tanzania's law and policies about abortion are inconsistent and unclear. They continued to observe that most people in Zanzibar believe that all abortion is illegal. In Zanzibar, women described a range of abortion methods and experiences, most of which terminated the pregnancy without physical sequel or need for PAC. It is possible that women who had a doctor terminate their pregnancies were given prophylactic antibiotics, thus reducing the risk of infection and potentially seeking formal PAC at the hospital; two participants mentioned being given pills by the doctor but they did not know what the pills were. It cannot be authoritatively asserted whether abortions in Zanzibar are safe or unsafe.

Moreso, Rasch, Sørensen, Wang, Tibazarwa and Jäger (2014) reports that in Tanzania women used medical personnel to assist them carry out abortions outside designated health facilities. This reduced the level of risk although perception is that abortion is illegal. Most women were reported to have used misoprostol or MVA for an early termination and later presented themselves for PAC for perceived incomplete abortion. Many could not tell the qualifications of the medical personnel who helped them. Rasch et al. (2014) conclude that persistent use of these unregulated methods reflect the lack of easy alternative abortion options and signify the need for abortion policy which will pave the way for safer abortion services.

Maina, Mutua and Sidze (2015) in their Kenyan study used a nationally-representative sample of 350 facilities (level II to level VI) that offer post-abortion services for complications following induced and spontaneous abortions. The health providers involved in the study were drawn from 328 facilities to collect information on socio-demographic characteristics, reproductive health history and contraceptive use at conception for all patients presenting for post-abortion services. The analysis was based on data recorded on 769 women who were classified as having had an induced abortion. About 16 % of women seeking post abortion services for an induced abortion reported to have had a previous induced abortion. Being separated or divorced or widowed, having no education, having unwanted pregnancy, having 1–2 prior births and using traditional methods of contraception were associated with a higher likelihood of a repeat of induced abortion.

Kumar, Baraitser, Morton and Massil (2004) examine the experiences of service providers in Britain British focusing on health services access and quality. They note that the process of seeking abortion in the UK is sometimes confusing because of inadequate information and extended because of delays in referrals. In Felding et al, (2002) participants compared positive experiences of treatment by professionals providing medical induced abortion in clinical trials with professionals' negative attitudes and impersonal clinic settings in ordinary services.

McIntyre, Anderson and McDonald (2001) shows that women normally compare their expectations with the kind of services they receive. The results identify a mismatch between women's normative expectations that health care providers should provide women and what they perceived to be an unsympathetic reception from medical staff. The effect of such attitudes is assumed to discourage women from seeking abortion, but there is no systematic evidence to support this assumption.

Researchers like Bennett (2001) have noted that the attitudes and feelings of health providers to abortion were relative to the marital status of the women. Bennett cited an example of Indonesia where medical staff endorse abortions as a form of birth control for married women, but were disappointed by tendencies of pre-marital sex which impact on young women's feelings of guilt and shame. Similarly, a study on teenage mothers in the UK by Lee et al., (2004) also reported doctors' disapproval. In the UK, clinical attitudes appear to be more negative towards the

induced abortions after the first trimester and some NHS clinics do not offer services for late abortions.

Another positive experience is in counseling is referred to in different ways in the studies but most particularly as counseling prior to the induced abortion to discuss the different methods, their benefits, what to expect, compliance and follow-up Felding et al, (2002) and in relation to decision-making to undergo the induced abortion (Kumar et al. 2004).

Other studies (Alex and Hammarström, 2004) take a nursing perspective referring to the emotional work of nurses while other researchers noted that the importance of providing opportunities for women to express their suffering created positive experiences and less pain and mental stress (Kero, Högberg & Lalos, 2004). The importance of counseling is thus highlighted particularly where women had not told family or friends about their pregnancy as noted by Kumar et al., (2004).However, Lee et al. (2004) maintain that unnecessary or superficial counseling has also been questioned. In some developing countries where women are more vulnerable, Lafaurie, Grossman, Troncoso, Billings and Cháveze (2005) argued that the women's decision-making regarding abortion was influenced by the recommendations of the abortion provider and cost implications.

Yet in other studies, information provision and knowledge were critical factors. For instance, literature shows that an American study recommended that each patient be given a choice in the amount of information she receives, and information packs could be provided accordingly (Felding et al, (2002). In relation to contraception however, knowledge needs to be integrated into practice for effective family planning (Törnbom & Möller, 2009). Other positive experiences come from the physical setting for example waiting rooms and cold, unfamiliar wards were also referred to in some studies (Alex & Hammarström, 2004). While some women appreciated the presence of other women in alleviating the loneliness of the experience, others were concerned about privacy and the risk of meeting someone they knew in the waiting room (McIntyre et al, 2001).

Finally, some studies also investigated women's positive experiences of medical induced abortion at home rather than at a clinical facility (Lafaurie et al., 2005; Elul et al., 2000). In the

US, Fielding et al., (2002) and Elul et al. (2000) identified familiar surroundings, privacy and not having to encounter strangers, as adding to women's appreciation of home induced abortion.

In most of the above studies, the authors focused much on the environment surrounding the women who later aborted. In the current study, focus is on both the personal and environmental factors which combined to cause the lived experience. The current study found out that both personal and environmental factors interplay and are of equal importance in determining the overall experience.

2.4.2 Negative experiences of abortion

Rees (2007) (p.430-436) found out that women who have an abortion are not at higher risk of depression than those who give birth. Rees (2007) seems to assert that the positive association between induced abortion and depressive symptoms cannot be explained by pre-pregnancy depression.

In a counseling psychology study done in Ethiopia, Kidist (2015) found out that when women were asked if there is any positive or negative impact of abortion on their social experiences, some of the women said they are getting relieved from their problem and if there was no abortion service they don't even know what to do. (p.51). He also notes that most single women broke up their relationship with their partner for not getting financial and emotional support. Women who couldn't share their experience with family, spouse, relatives or close friends felt that they were hiding some secret from them and felt as if they betrayed them. Majority of the women needed to get assistance from the people they value but couldn't request because of cultural influences and fear of not being accepted by them.

Bellieni and Buonocore (2013) enlists negative responses including sorrow, sadness, guilt, regret, grief or loss and disappointment responses as being associated with induced abortion. Their methodology of questioning was based on measures used by previous studies from the 1990s such as Major et al.(1992) and Broen et al.(1993). In their study, the questionnaire items were coded on a three-point scale reflecting the extent of response (not at all, somewhat, very much). This indicated that predominantly negative reactions were realized by the researchers

thus justifying that induced abortion creates negative experiences regarding the process of inducing an abortion among women who underwent induced abortion.

Similar to the above study, a recent study by Rocca et al.(2015) negative emotions from experiences of abortion procedure included regret, anger, sadness and guilt over 3 years post-abortion. In the same study it was noted that approximately 6% of women experienced an increase of at least a point in negative emotions over three years of post-abortion.

Authors noted that there are situations in which home abortions are problematic, for example where the induced abortion needs to be kept hidden from the rest of the household because of shame (Bennett, 2001). Bennett (2001) emphasise that this is particularly complicated where women are victims of domestic or sexual violence. Women also fear the risks of having an abortion at home where health professionals are not readily available to them.

In Malawi, Levandowski, Mhango and Kuchingal (2013) indicate that 24% of maternal deaths in 1999 were attributable to post-abortion complications. This was also a negative lived experience for women who had survived death due to complications of induced abortion in Blantyre and Lilongwe. However, their study was limited owing to failure to involve more key informants about reported negative medical experiences of women. The study also is limited to the effect that it does not provide national estimates of the number of women treated at all facilities.

Maina et al. (2015) notes that, in many countries where provision of abortion is restricted or is of low quality or inaccessible, women often resort to unsafe methods that result into complications, long-term health problems or even death. This is due to the fact that, abortion care is more than just an abortion procedure. A comprehensive approach comprising of counseling, safe abortion services and other reproductive health services, like diagnosis and treatment of STIs or addressing needs of women subjected to violence is often required.

Maina et al.(2015) further note that in the last decade, studies that have attempted to understand the motivations for abortion have arrived at very convergent results. The most cited motivations were the rejection of pregnancy itself; abortion as a contraceptive method; the lack of partner support. Other reasons advanced were the difficulty of access to family planning services or emergency contraception; socioeconomic factors like unemployment or fear of losing their jobs;

fear of the reaction of parents or disappointing them. It was also indicated that domestic violence in terms of sexual, physical, psychological and sexual coercion perpetrated by intimate partners and family; marital status like being single or being in a complicated relationship; the desire to not drop out of school also contributed motivations for abortion.

Nader et al. (2007) found out that most women who had induced abortion did not plan for the pregnancy, although some expressed the desire to keep it. However, giving in to the pressures imposed by the situation they were in, they eventually did it against their will. Mariutti, Furegato, (2010) on the other hand, conducted a study at the University of São Paulo (USP) and found out that the difficulty of coping with both the pregnancy and having induced an abortion can affect the mental health of these women, being at risk for developing anxiety and depression, and these may be demonstrated even years after the fact.

Another aspect of painful post-abortion experiences shows that the decision to abort, often encouraged by the partner, shows that there was no planning carried out by the couple (Nader et al. 2007). In this context, there is often domestic violence present, identified in the pressure exerted by the partner and family, which overrides the desire and the freedom of women who without support to maintain pregnancy surrender to passivity, overcome by feelings of guilt, shame, anxiety, low self-esteem and humiliation.

Boemer and Mariutti (2010, p.13) note that denial of care and attention given by professionals because they are unprepared in not knowing how to deal with their own beliefs and values can trigger a series of feelings that will reflect on the meaning that the woman will give this experience, especially when hospitalization is considered uncomfortable (Boemer & Mariutti, 2010). It can cause shame, a fear of being blamed, anger, feelings of abandonment, among other feelings.

Other researchers like Dias, Passini, Duarte, Sousa and Faúndes (2014) have found out those women who are emotionally attached to their religion feel that they greatly sinned to commit abortion and carry with them a moral burden and suffering in this respect. Dias et al.(2014) shows that women are unfairly blamed when it comes to issues of abortion without having any

moral responsibility to the men involved. The author does not condone abortion but rather questions why men at large are not held as accountable as women.

Other studies highlight the isolation of women undergoing induced abortion and their concerns to conceal it from others (Alex &Hammarström, 2004). This reflects a guilt feeling and thus negative perception and experience. Studied have documented several accounts of women who secretly undergo abortion without involving any family member (Lafaurie et al, 2005; Fielding et al, 2002).There are accounts of women who undergo the abortion alone, or in secret with others such as family members around but unaware of the situation. In contrast, women in another clinical trial, Elul et al.(2000) described the active participation of partners or friends who helped to minimize their discomfort by rubbing their backs, bringing them tea, or monitoring their blood loss. Literature from Lafaurie et al, (2005) also shows that women with knowledge of how induced abortion works, and who have support from both their clinic and their partner seem more likely to experience a better outcome.

On the other hand, a Ugandan study by Rakai Health Sciences Program (RHSP, 2010) reported that interpersonal violence and sexual coercion are major problems in Rakai District. The study indicated violence of up to 30% and sexual coercion was up to 24% of the reported cases. The report noted that sexual coercion is associated with reduced contraceptive use, increased unwanted pregnancy and induced abortion. Coercion at first sex is also associated with the subsequent risk of HIV infection and induced abortions leading to physical social and psychological consequences. Women who were coerced at sexual debut reported higher rates of subsequent abortion than those who reported consensual sexual debut (Polis, 2009: p. 432). The research however did not give adequate focus to negative lived experiences from women who had undergone induced abortion in Rakai but rather how violence leads to unwanted pregnancies and induced abortions.

In another study by Katrina et al. (2011), participants were asked about the experience of induced abortion process. It was noted that their procedure was made more positive by nonjudgmental staff who conveyed genuine concerns, the kindness of the staff especially the nurses who were nonjudgmental, very supportive, and some felt the absence of their families was made up well by the friendliness of the nurse.

Furthermore, in a qualitative study done by Katrina et al. (2011 women who had undergone induced abortion reported feelings of stigma, secrecy and isolation following the events surrounding how they went through the abortion. This made the whole process more upsetting.

Whatever women's circumstances, studies in this review suggest that the decision to seek induced abortion usually precedes any encounter with heath care professionals (Lee, Clements, Ingham and Stone, 2004; Fielding Edmunds & Schaff, 2002). However, Andrews and Boyle (2013) recently warned that such decisions are moderated by the value systems and social norms of the society or community in question.

2.5 Short and Long-Term Lived Experiences after the Induced Abortion among Women Who Had an Induced Abortion

2.5.1 Positive Lived Experiences after the Induced Abortion

There is a paucity of studies in the abortion literature that focus on positive outcomes or meaning-making associated with having an abortion, despite the fact that the empirical evidence overwhelmingly indicates that the most common short-term reaction to having an abortion is one of relief (Allanson, 2007; Broen et al., 2005) and that abortion is highly related to important positive life outcomes concerning education, career trajectory, and income level as compared to women who carry unplanned pregnancies to term (Fergusson, Boden & Horwood, 2007).

Qualitative research demonstrates a variety of positive short and long-term outcomes that can be associated with the abortion decision, including relief, sense of control over one's life, maturity, improved self-image and self-esteem, overall improved psychological health, as well as improved relationships with parents, significant others, friends, one's children, health providers, and oneself (Lunneborg, 1992). Additional critical outcomes from a public health and social justice standpoint include vastly improved educational and career opportunities (Bailey et al., 2001; Fergusson et al., 2007) and multiple studies suggest improved use of contraception and reduced risk of subsequent pregnancies following an abortion (Bianchi-Demicheli et al., 2003) although reports do not always show improved use of contraception over the long-term (Bender & Geirrson, 2004). In contrast, giving birth to an unplanned pregnancy, especially for very young or unmarried women, seriously restricts educational and professional opportunities.

One qualitative researcher who also had an abortion when she was 24 years old stated, "I'm trying to lift the lid off the corner of reality that isn't a polite topic of conversation. And the reality is that for millions (billions?) of women the abortion decision is positive for their lives. And the truth as I see it is that an unwanted pregnancy, like any crisis, can be turned into an opportunity for growth, for maturation, for making wise, lifelong choices" (Lunneborg, 1992: p.5). Specifically, Lunneborg wanted to fill a gap in the literature about the ways that abortion can be, and often is, used to empower women. Lunneborg stated, "you can do more than simply terminate an unwanted pregnancy and more than simply get on with your life afterward. You can use your abortion as a stepping stone for thinking about and deciding other important issues in your life" (p. 4).

Similarly, to the concept of 'posttraumatic growth' or 'benefit finding' in the health psychology literature (Helgeson, Reynolds, & Tomich, 2006) even if the decision to have an abortion is complex and emotionally difficult (Bradshaw & Slade, 2003), it can also be an important inflection and reflection, point in women's lives, and may lead to positive effects in the long-run if the experience leads women to evaluate (and as necessary, make changes in,) their life, purpose, and behavior.

In the above literature, authors are rather closed with minimal details of what is really exciting to the mothers about inducing an abortion. In the current study, detailed accounts of women who were excited to have induced abortions are given with an insight to inform policy makers and practitioners of the best way to help the women who think abortion is a positive action.

2.5.2 Negative Lived Experiences after the Induced Abortion

The experiences of women who underwent induced abortion are very appalling. The immediate experiences after the abortion were feelings of sadness and emotional pain. Some women reportedly have strange feelings for killing a life. Others are filled with a sense of emptiness especially when passing through the middle of a ward with mothers having their babies (Machado et al., 2016). In other cases, women, no matter how compelling the reasons they had for seeking an abortion, still perceive the act of induced abortion as a violent killing of their own child. Consequently, this subjects them to pain, fear, guilt and anxiety much as the procedure was perceived as an act of grotesque and violent death (Agrawal, Praween & Seyeed, 2012). In

my view, although the studies bring out some of these short and long-term lived experiences vary, there is need to understand what drives these experiences and what women in Rakai have to say about their own experiences.

Research also shows that the psychological drawbacks of abortion have been studied in order to offer complete information to the women who hesitate when facing a difficult pregnancy (Geller, Psaros, & Kornfield, 2010; Mann, McKeown, Bacon, Vesselinov and Bush, 2008). In the last few years, these studies have become more and more frequent, and a constant update of research evidence in this field is needed.

Lie, Robson and May (2008) argued that most feminist researchers provide insights into the interaction of induced abortion with notions of reproductive independence. A study by Kero et al., (2003) on the long term emotional effects of abortion found that more than half of the women who had reported both positive and painful feelings continued to report these feelings after 12 months.

A more recent study by Andrews and Boyle (2013) of African-American adolescents (n = 12), aged between 15 and 18 years, highlighted their poor knowledge of reproductive processes and health and suggested that elective induced abortion was a 'positive, growth-enhancing experience' (p432), with participants being empowered by their experience of decision-making. Warren, Harvey and Henderson (2010) in their study reported that women had experienced negative mental experiences. They also assessed only a possible correlation between abortion and depression. Studies by Rees and Sabia (2007), Pedersen (2008) found out a correlation between abortion and depression along with other outcomes such as anxiety disorders or substance abuse disorders. Finally, Kersting, Kroker, Steinhard et al. (2009) found out that there was a correlation between abortion and loss of self-esteem alone.

Some research papers used as outcomes the rates of psychiatric visit or psychiatric treatment taken from databases (Munk-Olsen, Laursen, Pedersen et al.2011; Reardon, Cougle, Rue et al, 2003) these papers studied illicit drugs, alcohol and smoke use as the only outcome in various countries. They also found out that there was a correlation between abortion and both substance abuse disorder and depression.

Some scholars have been less accepting both of the inevitability of women experiencing their abortion as a traumatic experience and of the development of any psychological symptoms, much less a severe psychological reaction that could be classified as PTSD. The literature originally used to support the development of this syndrome has been criticized for being biased, focusing on women with very late-term abortions that for a variety of reasons were much more likely to be traumatic, and therefore not representative of a typical first-trimester elective abortion (Major et al., 2009). A recent review article entitled "Is there an "Abortion Trauma Syndrome"? Critiquing the Evidence" responded in the negative, reporting that literature demonstrating a causal effect between abortion and negative psychological outcomes was methodologically flawed and reiterated earlier contentions that following abortion, "clinically significant adverse symptoms occur in a minority of women, and when they do occur, their stronger predictor is mental health before the abortion" (Robinson et al., 2009, p. 269).

On the hand, studies show that the experience of having an abortion is a common occurrence, and it causes multidimensional experiences including physical, emotional and relational impact on lives of very many women who undergo it. Abortion is one of the silent killers of women, with an estimated number of women who die every year going up to 46,000 because of unsafe abortions (WHO, 2012). A very large number of these women (5 million) get serious life time complications that may be either temporarily or even permanent (Shah, et al., 2009). These mothers are not only affected by physical conditions but many are affected by even psychological conditions that may even be more difficult to assess (Worell, 2001). Among others, the results of unwanted pregnancies and abortions can cause a lot of hard life experiences to many young women such as being forced to quit school, having to encounter family, religious and community rejections and at worst being forced to marry or even experience very serious physical harm in some societies (Atuyambe, L; Mirembe, F; Johansson, A; Kirumira, E.K; Faxlid, E, 2005; Singh, et al., 2010).

Another retrospective study was done by Gravensteen et al.(2013) in two University hospitals in Norway. They note that women's experiences and appraisal of the care provided by healthcare professionals before, during and after stillbirth as a result of previous induced abortions. Findings revealed that independent risk factors for a high symptom level were young age and high parity at the time of stillbirth and prior induced abortion. Having held the baby appeared to

be protective for the women who did not face this long term effect. The researcher feels that whether young or old, the issue of short and long-term experiences after induced abortion needs thorough investigation to see if there are any similarities or differences with previous studies.

It is however important to note that much less has been studied on stigma related to abortions (Shellenberg, et al., 2014). Besides the little literature present on the abortion stigma, it has been hypothesized that the stigma following induced abortion affects women negatively, where this include their mental health as well as leading to cognitive and emotional implications of concealment (Major, et al., 1999; Major, B; Appelbaum, M; Beckman, L; Dutton, M.A; Russo, N.F; West, C, 2009). Such kind of psychological damages can affect the women's willingness to open up on their intentions to abort.

Similarly, in another study carried out in India to understand the psychological problems after abortion, 21.3% of women reported in affirmative. Two out of five women reported to have experienced depression and eating disorders after abortion. The second (25%) most frequent problems were sleep disturbance and nightmare. Less than one third of women reported anxiety attacks (Agrawal, et al. 2012).

Some authors like Astbury-Ward (2008) suggested that all women confronted with an unwanted pregnancy may experience some level of ambivalence.

Hemmerling, Siedentopf and Kentenich (2005) argue that ambivalence is a significant confounding feature associated with the decision-making process. Thus, ambivalence surrounding the abortion decision by women who undergo induced abortion is one of the most potent predictors of problematic post-abortion emotional adjustment as noted by Stotland (2001). In my view, this may determine the level of coping with or dealing with long-term experiences and how women perceive these lived experiences.

Different results were got from a Nigerian study by Bankole et al.(2015). Reasons for women's not receiving care after their lived experiences from induced abortion included: stigma, cost, and distance to a health facility and death before having a chance to receive care. In the long term experiences, feelings of ambivalence were more commonly reported by women with greater religious bond, mainly Catholic (Machado et al., 2016). Further still Cockrill et al., (2013)

reported affected women suffered self-isolation and frequent self-judgment. However, even women with higher religiosity denied having feelings of regret for the decision of abortion and reinforced that they would terminate the pregnancy again if such prior reasons and circumstances manifested (Kero et al., 2000). Through questionnaires, given to 5190 women, results showed that the most recurrent and immediate feeling after an induced abortion was relief, however that two of every five women experienced negative feelings of sadness, shame, judgment, sadness, and guilt (Foster et al., 2012)

Bellieni and Buonocore (2013) however, deviated and thus categorized his studies as Abortions, unplanned pregnancies ending with childbirth. In his findings, four studies found a higher risk in the abortion groups and three, no difference. The researchers also showed that three studies showed a greater risk of mental disorders due to abortion, while others found no difference and some found a short-term anxiety and depression pattern higher in the miscarriage group. In essence, fetal loss seems to expose women to a higher risk for long term psychological or mental disorders than childbirth; although to prove this, more empirical research is needed in this field.

In another study by Machado et al. (2016), women reported resistance and discomfort from some health professionals, when they expressed personal and religious opinions. Their reactions triggered feelings of guilt and shame, and sensation that they might be doing something wrong. Whereas Hessinin (2014) earlier noted that stigma of abortion can be revealed on a number of levels, starting from individuals to systematic levels, not only here but also attached to other forms of repressions including religious, sexism, racism, cultural and socioeconomic inequalities (Hessini, 2014). This doesn't affect women's physical and mental health including disclosure decisions, but it leads also to discrimination (Major, et al., 2005).

Abortion is widely present though still socially proscribed in some countries, such as South Africa. Whereas in some other countries it is a surreptitious practice which cannot be accessible, which then result into the negative outcomes for women (Kate et al., 2014). Literature states that always women are met with suspicion and even hostility after having had an abortion (Ringheim, 1999).

Finally, Dykes, Slade and Haywood (2011) carried out a study to explore women's long-term experiences and perspectives on their induced abortion. In their study Five induced abortion themes were identified: 'Impression left' involved sadness, regret, and guilt which affected women's self-perceptions. 'Judgment' encompassed judgment on themselves and how censure was feared from others. 'Growth and development' noted the development of resilience and compassion for others. Considering induced abortion together revealed that; Changes to thinking, Menopause as a time of reflection and Linkages or separateness. For some women termination may be continually reappraised in their changing life context and remain an active yet hidden feature managed through active avoidance.

Uganda and induced abortion

The Ugandan Ministry of Health estimates that as of 2008, 26% of all maternal deaths result from abortion complications. This is aggravated by legal, socioeconomic, and geographical barriers to safe abortion, which compel women to use unsafe abortion methods and deter them from seeking post-abortion medical care (Migiro, 2013).

Akinrinola et al. (2013) show that in 2013, an estimated 128,682 women were treated for abortion complications and an estimated 314,304 induced abortions occurred. Unsafe abortion remains a major problem confronting Ugandan women. Although the overall pregnancy rate and the abortion rate declined in the past decade, the majority of pregnancies to Ugandan women are still unintended. These findings reflect the increase in the use of modern contraception but also suggest that a large proportion of women are still having difficulty practicing contraception effectively. Improved access to contraceptive services and abortion-related care are still needed.

The Ugandan Penal Code of 1950 indicates criminal penalties for anyone who obtains an abortion or contributes to the procurement of one (Center for Health, Human Rights and Development (2016). There is one exception permitted–if the abortion procedure is to save the woman's life (United Nations, 2009). Court cases have since expanded the interpretation of the life indication to include preservation of a woman's physical and mental health as well. The Ministry of Health's (MOH) National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights specify a number of health grounds under which abortion is permitted, including rape, incest and defilement, or if the woman has HIV; these policies also

expand abortion provision allowing access to the service at facilities ranging from Health Center IVs through the referral hospital level. However, it is difficult to ascertain whether an apparent clinical life risk will be seen as such under the law, especially if there are conflicting medical opinions on the level of risk a woman is facing.

In summary, the above literature indicates that the way a woman experiences an abortion, and specifically whether or not it will be associated with negative psychological outcomes, is quite complex. While the short and long term effect of abortion and physical pain, poor mental and psychological health appears to be quite modest, a number of factors have been identified that may predict poorer psychological outcomes following an abortion. A general observation is that different women experience varying mental health short and long-term outcomes of induced abortions which are either positive or negative. From the above, this study sought to generate important local information on the lived experiences of women who underwent induced abortion in Rakai District and allow for creation of appropriate policy interventions.

2.6 Conclusion

Major methodological problems pervaded most of the research reviewed. Other studies are limited by legal challenges regarding induced abortion particularly in Islamic and traditional societies such as those reviewed in Iran, Nigeria among others. More so, most studies report lived experiences as random effects or emotions rather than getting firsthand information from affected women who have undergone induced abortion. Other studies were mainly comparative between women who had undergone abortion and others who were pregnant. A common issue in literature is the commonest risk factors, for example ambivalence about having an induced abortion or pregnancy among women in various settings where studies have been done. Another common misconception among researchers is the expectation that one will have more negative feelings about the abortion. All these gaps necessitated this study. The study overcome many of the limitations above by adopting a one on one approach, using snowball sampling, sticking to the issues as stated in the objectives and avoiding being judgmental. Consequently, results obtained bridge the gaps as described in the subsequent chapters.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter gives an overview of the study area, research design, study population, sampling and sample selection. It also describes methods and tools that were used in data collection and how data was analyzed, processed and presented, the ethical considerations of the research and dissemination of the findings of the study.

3.2 Study Area

This research study was conducted in Rakai District. The district is located in the Southwestern central region of Uganda. Rakai District was selected because it was one of the places in Uganda which was hard hit by HIV/AIDS in the past and known for promiscuous sexual activities where unwanted pregnancies are rampant. The researcher also selected the place because was associated with lower costs of the study and availability of contacts that would ease data collection.

3.3 Research design

Research design is a plan and procedure for the research that spans the decisions from broad assumptions to detailed methods of data collection and analysis (Creswell, 2007). A cross-sectional study design of qualitative research method was used. A phenomenological approach of qualitative study design was utilized. Such framework enables the understanding of human phenomena that occur in the world of life, also called the social world (cited in Ndunyu, 2013.).
The theoretical assumptions of body of knowledge, biographical situation, and social action, guided the discussion of results. A questionnaire was used with a combination of qualitative methods, analysis using phenomenological approach to extrapolate themes using grounded theory.

3.4 Study Population

The population of interest for this study included only women who live in Rakai who underwent induced abortion. The researcher interviewed twenty-five women who had induced abortions in the past one to three years.

3.5 Sample Size Estimation

Finlay (2011) and Smith, Larkin and Flowers (2009) recommend that when utilizing the phenomenological methods of research, the sample size should range from five to 25 participants. The study considered a sample of maximum 25 participants of women in Rakai District who had induced abortions in the past one to three years. This sample size provided a platform for in depth analysis of the participants' phenomenological experiences.

3.6 Sampling procedure

Participants were selected purposively basing on the available records. In some instances, snowball sampling if the participant knew of any other woman who had had an induced abortion. The information from women who underwent induced abortion was obtained from health facilities within Rakai district.

The advantage of this method is that it enables the researcher to identify respondents of interest from people who are rich with particular information (Creswell, 2007). Still; this method enabled the researcher to obtain an in-depth understanding of the phenomena of interest.

Snow ball sampling was considered to be more likely to capture women who had recent induced abortions and/or more complicated abortions, as these were remembered more by their acquaintances. Alternatively, women with complicated induced abortions were less likely desirous of participating. By its design, the study only captured women who had told someone about their abortion and excluded women who kept abortion as a top secret.

Finally, women with unsuccessful induced abortions and women who died were not captured with the sampling design. Because the study would capture and recruit only women who did abort a pregnancy, the study design excluded women who tried but failed to abort a pregnancy.

3.6.1 Inclusion criteria

All women who were eligible for the study participation had to meet the following requirements;

First of all, women who had an induced abortion in the last three years and were identified as residents of Rakai district were eligible to take part in the study.

Women Aged 18-49: This age bracket helped to minimize cohort differences, based on the UBOS 2012 analysis and the ever-changing socio-cultural norms regarding abortion.

Post-Abortal of one to three years: Based on Interpretive Phenomenological Analysis (IPA), the methodology is concerned with the meaning someone ascribes to an experience. Thus, it was of value that the enrolled participants were able to reflect deeply on the experiences of their abortion and were able to articulate their insights and their best understanding during the interview verbally.

Abortion experience can also cause physical and psychological complications, thus it would be of great value if the enrolled participants had a prior opportunity to adjust physically, spiritually, and emotionally. A range of one to three years provided an assurance that women had enough time to process an induced abortion experience, and also recall accurately meaning-making and decision-making processes, because as time goes on various life events after abortion experience can affect various critical factors such as meaning-making. This also increased the chance of targeting women with similar emotional and cognitive processing regarding induced abortion experience.

3.6.2 Exclusion criteria

Eligible women who refused to consent were excluded from the study. Also women who had an abortion more than three years ago were not enrolled into the study.

Eligible women who were sick, unconscious or mentally unsound were excluded from the study because they were unable to give trusted and credited information about the phenomena under the study.

Eligible women who were identified with other obstetric complications that followed after an induced abortion; for example, loss of a uterus because at this time they would relate all their experiences to that loss not the induced abortion thus recall bias and un-coordinated information would be reported.

3.7 Study Variables

3.7.1 Dependent variables

These among others include unwanted pregnancies, induced abortion, positive and negative, lived experiences of the process of inducing an abortion among women, positive short and long-

term lived experiences after the induced abortion and negative short and long-term lived experiences after the induced abortion

3.7.2 Independent variables

The independent variables include age, religion, marital status, occupation, level of education, exposure to information, ever use of contraceptives, history of induced abortion, reasons for induced abortion, age at first sexual intercourse, number of sexual partners and history of pregnancy

3.8 Data Collection Methods

3.8.1 Screening Interview

Already selected participants were asked to have a short brief interview either on telephone or by meeting with the principal investigator in person. This was done in January 2017. The interested participants were asked to confirm whether they had any history of an induced abortion and whether they fitted the above described study inclusion criteria. Women were also excluded if they weren't living in Rakai and if they had the abortion more than 3 years ago (Appendix B). This was aimed at reducing recall bias. Every woman who passed the screening criteria was invited to participate in the study.

3.8.2 In-depth Interviews

The researcher collected data by conducting in-depth interviews with women who underwent an induced abortion. The use of in-depth interviews helped the researcher to ascertain the participants' views of the phenomenon, its description and to generate meaning from those who experienced it accordingly (Creswell, 2007). Participants were given choice of language between Luganda and English which allowed participants to express their experiences on induced abortion in a language they were most comfortable with (Cassell & Symon, 2004).

This interview was based on open-ended questions that allowed the participants to reflect on quite broad subjects related to their experience of induced abortion; this was followed up by some kind of probing questions in order to explore the areas of interest in details. The interviews were run with gaps of breaks where necessary and participants were given some refreshments in these breaks. All participants had to answer the following questions in sequential order, with potential follow-up probes, though these were varied according to the participant's openness, response and the interview course (Appendix D). In the in-depth interviews participants were

conducted until there were no new ideas generated or expressed by them; what is termed as ‘a point of saturation or redundancy’.

3.8.3 Tape recording

During the interviewing process, the researcher recorded all information appropriately using a tape recorder. This facilitated the capturing of every detail of information and avoiding omission of important information from the participants. In that event, this procedure made the participant comfortable to share all the experiences which she went through. She was informed of the confidentiality of the information recorded and wherever the respondent opted that her voice should not be recorded; such information was recorded by writing of all details as the respondent narrated.

3.9 Study Variables

This section explains the variables relating to study objectives. They included among others: both dependent and independent variables for each objective. They were solely on women who underwent induced abortion in the past three years. Independent variables for each objective were analyzed such as identification of women who had experienced long-term post-induced abortion; an estimation of proportion of women who suffered short and long-term post-abortion lived experiences. Demographics were also assessed to determine their influence on the lived experience after induced abortion were also considered.

3.10 Quality control

3.10. 1 Validity

Validity is the degree to which a result obtained from the analysis of the data actually represents the phenomenon under study (Creswell, 2014). Internal validity, which is a measure of reality of the results because of the way respondents are handled (Cameron et al., 2007), was achieved by impartially handling all the respondents and interviewing respondents using a semi-structured interview guide. The study also assessed whether the findings can be applied to other populations and this was a pointer to validity.

3.10.2 Reliability

Reliability was achieved by developing themes out of the responses. These were further explored and studied by comparing scrip by scrip until generalizations were made to make conclusions.

3.11 Data Management and Analysis

3.11.1 Data management

The researcher ensured that during and after data collection, data was kept confidential and out of reach of unauthorized people. The researcher transcribed verbatim by playing the audio recordings and writing in a note book what was recorded. After transcribing the recorded data, the researcher checked for accuracy if it was in line with the participants' narrations by listening to the recording while following the text written.

3.12 Data Analysis

Data analysis in this study followed the steps adopted by researchers in the tradition of the social phenomenology of Alfred Schütz (cited in Carvalho, Merighi and Jesus 2010) which includes reading; detailed re-reading of each testimony to grasp the experience's global meaning; identification and later grouping of the significant aspects of testimonies to compose concrete categories – objective syntheses of different meanings of actions that emerged from experiences; analysis of these categories; and discussion of results based on the social phenomenology of Schütz.

Qualitative data collected from interviews was analyzed by thematic content analysis. This is a research tool used to determine the presence of certain words or concepts within texts or sets of texts. Six hours of recording was integrally and literally transcribed into verbatim transcripts which were then analyzed to identify patterns and themes for thematic content analysis. The transcriptions were coded, into manageable categories (words or themes with similar meanings or connotations) of a variety of themes focusing on and coding for specific words patterns that were indicative of the research question. However, new patterns and themes identified from the data were added; thus analysis was both deductive and indicative.

The process of data analysis in phenomenological studies goes in a back and forth manner throughout the data collection and transcription activities and throughout the extraction and

construction of codes and categories, writing memos and the writing processes (Ndunyu, 2013). Ndunyu (2013) further notes that handling of the data records should be carefully managed to construct good explanations and predications from the emergent ideas, categories, concepts, themes, and hunches (citing Richards, 2005:1).

3.13 Ethical considerations

An introductory letter was obtained from the Faculty of Health Sciences of Uganda Martyrs University that introduced the researcher to the authorities in Rakai district particularly to the District Health Officer. A letter of information with a comprehensive description of this study was made available to all eligible participants (Appendix E). Informed consent was made available to the participants after their acceptance of inclusion and also before the study was conducted (Appendix F). The client participation in this study was voluntary and participants were free to withdraw at any time without any penalty and they were reassured that this research was for academic purposes only. A consent form was only signed and dated by both the personal assistant (PI) and the participant after it had been read and understood prior to the interview session. Consent forms were read to the participant and her agreement to participate was audio taped. Pseudo names not real names of the respondents were used. This was to maintain confidentiality.

All participants were informed of the potential risks and benefits of their participation in the study to ensure their safety; this appeared as a note on their consent letters. Where any of the participants experienced any level of stress which would require professional help, support services were provided by the researcher through counseling. Participants decided, where, when and how contact was made. All interviews were conducted in exclusive places with only the participant and the PI present except when the participant allowed someone to attend.

Code system was used to ensure confidentiality such that participants' names did not appear on any of the transcripts and post data collection. All audio-taped materials, identifying information and all transcripts were kept under key and lock by the Principal Investigator (PI), and only the PI, supervisor and the evaluation committee members will have access to the data. All interviews were recorded digitally and the files were saved on password protected computers. All

recordings, transcripts, consent forms and all other related documentation were sealed in a box and secured in a protective custody.

3.14 Dissemination plans of the study findings.

On completion of the study, copies of the study report will be submitted to the Faculty of Health Sciences of Uganda Martyrs University for the academic award of Masters in Public Health-Population and Reproductive Health of Uganda Martyrs University-Nkozi.

Once the study is completed, the researcher will publish so that the findings may be used for programmatic activities targeting women who undergo induced abortion and all girls and women in the reproductive age.

Four copies of the report will be printed and submitted for approval then, a copy will be given to the District Health Officer of Rakai district where the study was conducted, copy to the faculty library, copy to the main library and one copy will remain with the researcher.

The participants will not be given copies as their details were not taken for confidentiality and privacy reasons.

3.15 Study Limitations

Participants were chosen specifically only when they met certain demographic and phenomenological criteria (Johnson, et al., 2008). For example, women below the age of 18 years who could not consent were not included in the study.

The study validity depends on a great deal of truthfulness, openness of participants, accuracy and completeness of data obtained. This may not always be the case given the sensitive nature of the study topic. The fact that induced abortion especially if not done on health grounds; is still illegal in Uganda, participants feared to be victimized. However, participants were counseled first to create a good rapport and told about the confidential nature of the study.

The study excluded mother who were under 18 which limited the number of possible respondents but was done to ensure good quality of respondents from the point of view of maturity in reasoning.

CHAPTER FOUR
FINDINGS OF THE STUDY

4.1 Introduction

This chapter contains the findings in accordance with the study objectives namely; the lived pre-abortion experiences of women who had induced abortion in Rakai District on learning about the aborted pregnancy; lived experiences of the process of inducing an abortion among women who underwent induced abortion in Rakai District; and the short and long term lived experiences after the induced abortion among women who had an induced abortion in Rakai district. Pseudo names of the respondents and not their real names were used. This is in observance of the confidentiality requirements. Data is presented according to the objectives with various respondents mixed but arranged according to the themes.

4.1.2 Characteristics of respondents

The respondents were 25 and were females who had induced abortions in a period not exceeding three years at the time the study was carried out. This implies they had short and long term experiences as framed and target by the study design. The participants were from several religious backgrounds including Catholics, Muslims and born again, with majority being Catholics. This provided a rich religious background for comparison of the views of people of different religious inclinations on the issue of induced abortions. The respondent's age ranged between 19 and 34, which also reflects majority of the women in child producing age.

The participants were mostly semi-literate with many having completed only up to primary seven (p.7) with only a few stretching to senior four and six while only one participant had reached University. Among the participants, only one had formal employment, 1 had semi-permanent employment two were school drop outs looking for survival from here and there, while the others were peasant farmers and housewives. The fact that many were out of school at a tender age exposed them to early sex and unwanted pregnancies. For instance, there was a surprising case of Harriet, a 19-year-old who confessed having 6 children, having aborted the 7^{th} pregnancy. This also means such people had conceived on their first ovulation and were not using family planning at all, and could not easily interpret family planning related information to help them avoid unwanted pregnancies.

Only two participants were married (Mary and Harriet), while the rest had got pregnant before marriage. This was one of the fundamental reasons for failing to appreciate their pregnancy status thus contemplating and actually effecting the abortion.

Given the location of respondents, all confessed to be Baganda or at least being attached to Buganda and thus able to speak Luganda. This justifies having a Luganda translated version of the interview guide which helped the respondents to follow the interview closely and feel at home during the interviewing sessions.

The study also found out that the timing of the abortion was varying from mother to mother, for instance, one mother confessed that her pregnancy was 3 months old by the time she aborted. The same mother had another induced abortion at 5 months. Another mother was 18 years old when she induced an abortion. The study found out that some mothers aborted pregnancies as old as 6 months. The order of the pregnancy did not matter as for example a certain mother aborted the 5th pregnancy. The next section explores the lived experiences of women who had induced abortion in Rakai District on learning about the aborted pregnancy

4.2 The pre-abortion lived experiences of women who had induced abortion in Rakai District on learning about the aborted pregnancy.

In this section, results on pre-abortion lived experiences are presented pointing out exactly what the mothers thought and experienced shortly before making the decisions to induce their abortions. All the interviews presented in this chapter were carried out starting 15th Feb 2017 and continued throughout March 2017.

Lack of commitment

Some partners were in relationships just for convenience. They had no plans of extending the relationships. One lady indicated she was only comfortable with the man as along as she did not produce for him. She thus narrated,

> *Angela: I thought it was stressful to tell my partner about this development. I didn't want to parent with him and I took our relationship just for companionship but not for a continuous obligation of a serious family.*

Fear of rejection:

> *Hajara: my parents would abuse and kill me on hearing that I am pregnant because I am their first born child and they have a lot of hope in me; so I decided to induce the abortion"*

There were cases where ladies would have loved to carry on the pregnancies but feared for the reaction of the conservative parents who were reasoning in terms of tribes. A lady assured the researcher that she was sure her parents would not accept a man from another tribe and this was the reason for abortion. She explained,

> *Ruth: My boyfriend was from another tribe and my parents would not have approved.*

From the above, the study depicts a mother who is not ready herself, who is not being helped by the family, at least from her perception, who is denied and thus helpless.

Shame

Another mother confessed that they had a mutual agreement with the husband not to produce any more children. She however had an extra marital affair which she suspected was the original source of her pregnancy. She thus confessed,

> *Harriet: "I felt ashamed and I had nowhere to start, how could I tell my husband that I was pregnant, besides I was not sure whether my husband or the other man was responsible."*

There were several other confessions of not being ready and a feeling of being caught unaware. In this line, a certain woman confessed,

> *Harriet: "I am the first born at home; my parents had a lot of hope in me. How could they feel on learning that I was studying and had become pregnant"*

> *Florence: Another woman, Florence confessed "….all I knew is where he was renting, I also didn't know the original home of my boyfriend only where he was renting.*

Unplanned pregnancy

From another married woman,

> *Harriet: "The decision between delivering a baby and inducing the abortion was so difficult for me, because honestly, this pregnancy was unplanned and I was not even sure of the owner"*

> *Irene: "Unfortunately, one time, my boyfriend, either intentionally or accidentally did not use any protection and I was in my unsafe days. Automatically I became pregnant*."

Some unplanned pregnancies were really complex. A lady who had not yet known her father never wanted her kids to undergo the same experience. Rather than giving birth to a kid whose father is not known, she would rather abort. She thus indicated,

> *Adrine: "I was not sure who my aborted child's father was. Still, I was not working, so I could not support myself just in case. I had not known my own father by that time (my mum was also a player somehow), and I wanted my child to know his or her dad"*

This however is not a justification since the father would be known after birth on account of resemblance but she feared for who would cater for her needs during the pregnancy.

At times, abortion was used as a family planning method. In this respect, one other mothers confessed that she had "many" children and thus did not want more. Still, extra marital affairs were part of the problems that some pregnancies were attached to. To illustrate this, a certain mother had this confession,

> *Racheal: "We had agreed with my husband to stop delivering more children so we would have those four children given our low financial status."*
>
> *Mary: "…. My husband buried the dead body. But I didn't tell him it's me who induced the abortion; I told him that it came out by itself"*

In the above case, the husband never consented to the abortions and this was an indicator that the pregnancy was not planned by either party culminating into women aborting their pregnancies.

The findings above are indicators of women who got pregnant when they least expected it and thus took the decisions of inducing the abortions.

Peer influence

The study also attempted to find out the moment when women decided to carry out an abortion. In this, the study found out the key influential people when making decisions to induce the abortions. The study found out that women consulted their friend, mostly those who ever had an abortion. Others consulted their grands on account that they had experience in local herbs; and

also partly because parents of the pregnant women would be so hostile and uncooperative. A woman for instance noted that,

> *Florence: "I got a friend to whom I disclosed my problem and she reassured me that since am still young, I will get another pregnancy so I can induce the abortion, for she had done it before!"*

Such assurance would serve only to encourage the woman to go ahead and abort.

Relationship complexity

The study further explored the reasons for inducing abortions. The researcher thus probed "***Why did you decide to terminate the pregnancy?*** In response, it was found out that there were multiple reasons for aborting. The study found out that relationship complexities were some of the key factors precipitating induced abortions. A certain woman revealed that she was not sure of the father. Another woman said,

> *Mary:"Why I induced the abortion the first time at 22 years, I conceived and my husband seemed loving at first but later started denying ownership of the pregnancy!! I had a girlfriend that also fell in a love relationship with my husband yet rumours were saying, she was HIV positive. So I got annoyed and I started……according to what the man had done to me, I decided to induce the abortion.*
>
> Phiona: "*this man made me pregnant but I had no single drop of love for him."*
>
> *Annet: "Towards the end of the fourth month, my boyfriend began behaving in a way that suggested he did not want my pregnancy"*

The study revealed that at the time of abortion, cheating married women could not tell the father of the pregnancy.

At times women were forced to abort as men denied responsibility for the pregnancies. This was revealed by one of the ladies, who said,

> *Hope: I introduced the subject of pregnancy to my beloved boyfriend. He certainly made it clear he did not want a child at that point.*

Another respondent indicated;

> *Adrine: "I was upset by my boyfriend and I decided to go for an abortion"*
> *Barbra: He insulted me and beat me up day and night. I decided very penitently on an abortion. I was raised in two-parent family and felt most strongly that a baby deserves the love of both the mother and the father. I was not seeing this kind of life ahead of my unborn child.*

> *Assumptah: "you do not belong to any one, how I can be sure it is my pregnancy"*

The study found out that most of the mothers did not plan for the pregnancies which were later to become induced abortions. In face of the pregnancy, many of the mothers were surprised, were in disbelief, were disappointed, expressed anger, confusion and generally not ready to take on the pregnancies. For instance, a mother confessed,

> *Hajara: "when I was pregnant, my life changed a lot because I turned skin colour from brown to dark, got wasted and I was so annoyed with myself. It wasn't a good experience at all, I missed period the 1st month and I ignored that but then I missed the 2nd month and I got scared then went to the nearby clinic where I bought a pregnancy test kit and it turned positive. I got so worried, lost weight because the man had denied ownership of my pregnancy.*

All these show how relationship issues contributed to tendencies to carry out abortions.

Another woman revealed how she was unfaithful and in the process got pregnant and she was not ready to be ashamed. She thus said,

> *Racheal: "Unfortunately, I stepped aside of marriage and got a man who impregnated me and I feared how I would explain that pregnancy to my husband, so I go challenged and I decided to induce that abortion."*

Another respondent revealed that by the time she got pregnant, she had multiple boyfriends and she could not hold any of them accountable with certainty, she thus said;

> *Grace: "I finally got pregnant, not even knowing whom to hold accountable for my pregnancy since I had multiple boyfriends".*

From the above, it can be inferred that the decision to terminate the pregnancy was a result of anger and the need to punish the cheating husband or boyfriend. On the other hand, the cheating woman could not help being exposed, all of which depict relationship complexities.

Poverty

In addition, the women were concerned about their welfare and the welfare of the baby. For instance, a certain woman, on becoming pregnant and while contemplating abortion,

> *Mary: "so I imagined if I deliver the baby, what I will use….like clothing….so I decided to induce the abortion because the man kept denying the pregnancy many times and I was challenged.*

The economic considerations were much pondering in the minds of women as seen above. More mothers also confessed to looking at the economic implications of the pregnancies they were carrying before finally deciding to terminate them. This was further aggravated by lack of support from the husband. Another respondent revealed that she did not want to lose newly acquired job. One of the respondents, a properly married born again, said,

> *Racheal: "My husband is not well off, our social economic status is poor, so this also greatly influenced my decision to induce that abortion. However, it was not in my plans of ever inducing an abortion in my life but I honestly had no alternative."*

A young lady confessed,

> *Hajara: "The boy I (fellow student) denied ownership of my pregnancy and I had no means of survival."*

Another respondent said,

> *Florence: "I had no financial support and where I was sleeping….!!But I tried to look for a job…in vain. So I decided to induce the abortion."*
> Nambi: *"Remember the boyfriend responsible for my pregnancy was not working, just a student like me. I did not even bother to tell him about the pregnancy. I chose to follow through with an abortion, sponsored by my Aunt*".

From the above, the study shows that financial support was a key issue for the women who later aborted.

Continuity of schooling

In addition, some women were concerned about their studies and had to weigh whether to forfeit the studies and carry the pregnancies or to abort and continue studying. One of the participants said,

> *Hajara: "I badly wanted to complete studies. I was studying in senior three going to senior four" another woman confessed "……this was because I wished to do my course in agriculture"*

Hajara added that,

> *"I was forced to induce that abortion because I feared my parents and I was still studying so I didn't want to spoil my studying opportunities. And then the owner of the pregnancy had also denied ownership of my pregnancy so I decided to induce an abortion. Still I was not ready to deliver a baby at that time because I wanted to complete my studies and it came by mistake."*

However, another respondent mentioned that her professional plan would have been destroyed.

> *Assumptah: "A baby would have broken up my profession plans……I couldn't bring a baby into this world without knowing how I was going to feed it, cloth it, love it and develop it."*

From the above, it is clearly indicated that such women or girls were deeply concerned about their future academics and this influenced whether or not to carry the pregnancies.

Feeling for the baby

The study further probed what women felt about the baby they were about to terminate. Surprisingly, many of the respondents did not seem to be concerned about what could happen to the babies. At the time, all their reflections were on the circumstances surrounding their pregnancy, for instance, financial support, studies, parent's reaction, saving their marriages, saving their jobs, their studies and their annoyance with the partners among others. The thoughts about the baby were more or less secondary at the time of aborting. Such memories only came later especially the bad experiences on not being able to have children, uterus being removed, seeing other people's children in the same age their aborted child would be among others.

Excommunication from family

Most participants revealed that they suspected that their parents would react in a harsh way on hearing about their pregnancies. So, as an escape route, they decided to induce abortions. A young lady who was still under the care of parents on getting pregnant and aborting had touching confessions when she said,

> *Flavia: "My daddy got to know about my induced abortion and he sent me away from home". She also added,*
> *Flavia: "Every person does not want to associate with me as before, even if I need anything, they just throw me away that am a spoilt child. My daddy drinks a lot and talks a lot of bad things about me in those different drinking places"*

Another respondent revealed,

> *Florence: "When I told him about the pregnancy, he said he has nothing to do for me with the pregnancy. my parents wouldn't accommodate my pregnancy, I decided to run away from home."*

Such scenarios as depicted in the above show parents who are not realistic and supportive to daughters who became pregnant.

Unwelcoming religious leaders

In society, most people who are neglected would be expected to turn to the religious leaders. In Rakai, this was not the case. There are examples to illustrate this, where for instance, as woman was concerned, expressing that,

> *Flavia: " .....imagine seems, elders and the youth leader, got to know of my abortion because the few times I have gone to church after the abortion, they talk about it so much!!!So now I don't want to go to church ...I just pray from here."*

From the above, instead of getting relief from the religious, this lady only found more grief and decided to keep home.

Use family planning

Most of the participants described abortion as sinful, murder, unreligious, terrible, among other words. A certain mother described abortion as a short term relief that brings permanent problems. From this feeling, one of the respondents recommended that,

> *Florence: "I advise women and girls, if they can't avoid those pregnancies through using family planning methods from trained health workers, then they should avoid sexual relationships to avoid even getting a child when still very young."*

Many of the women looked at induced abortion as not worthwhile and suggested that women need to distance themselves from any practices that would lead to such unfortunate action.

Lack of direction

Some respondents indicated that the acts of abortion were a result of lack of direction and poor upbringing. A lady confessed how she lived with an aunt who can best be described as a prostitute. Given this, she grew up with little regard for human life. She thus lived that she was not aware abortion was tantamount to killing. She observed that;

> *Nambi: I did not know that abortion was really killing. To make matters worse, when I went to University I stayed with my aunt whose true fiancé I did not know since she had quite a number.*

Medical advice

Some abortions were done for medical reasons. One of the ladies noted that much as she had prior abortions, there is a case where upon scrutinizing her condition, the medical workers

advised her to abort. In this case she felt relieved and had no regret since abortion was done for health reasons. She narrated,

> *Adrine: the clinician suggested it, because he said there was a 50% chance of the baby to survive. I listened to her and accepted to abort.*

4.3 The lived experiences of the process of inducing an abortion among women who underwent induced abortion in Rakai District

The study explored what exactly transpired in the process of inducing an abortion. Most mothers revealed that they were initially hesitant to visit professional medics and preferred to use local methods and local herbs. As the condition of the mother worsened, then they sought medical attention from qualified personnel. There is a range of methods and local herbs women confessed to have used, each with differing levels of success and risks as well.

Health complications

These included among others,

Near death experience

Another respondent confessed that she nearly lost her life due to severe bleeding and severe pain. In another related case, a mother confessed that,

> *Patricia: "I lost a lot of blood, and the baby didn't come out well."*

Severe sickness

Another respondent observed that local herbs failed. Later she got assistance from trained health workers; however, she got severely sick and weak.

> *Irene: Too much bleeding, high fever, headeache, backache, loss of appetite followed immediately. I knew it was time to say my last prayers and leave my young children*

Some mothers made enough preparations for the process of inducing abortions, including making prior arrangements with the health workers. This somehow reduced the risk in the process. A mother narrated for instance,

> *Hajara: "On deciding to induce the abortion, I got close to some medic and agreed to assist me induce the abortion. We made an appointment and so we induced the abortion, using tablets and then, he gave me tablets to help me heal*

properly. They were blood clots so I didn't see whether the baby was a boy or girl and I won't even want to know because I did not need that child at all."

From the above, it is indicated that the process of inducing abortions carried great risks with it, whether done by a medical professional or using local methods. In either case, mothers indicated that it was such a terrifying moment which they wished not ever to repeat or to be experienced by anyone. It however came out clearly that, the process of inducing abortion ended up being referred to qualified personnel else death would be more eminent. This could lead to the conclusion that the levels of risks are expected to reduce as more professionalism is available to handle the process of inducing an abortion.

One of the respondents, a young school going lady who became pregnant, confessed,

Mary: "I used local herbs and "tea leaves" then she (my friend) advised me that after its been aborted, they can give Erlangea tomentosa

As a result, this lady went through what she described as …terrible abdominal pain and severe bleeding.

Annet: "After a few hours, I saw heavy drops of blood coming out. Later on I felt as if I had labour pains. Then I fell unconscious. I woke up in a local clinic"

Another respondent narrated that,

Flavia: "I used roots of sugar canes, Commelinaceae and tea leaves…squeezed them together and I drunk them, then I aborted"

Following this, this respondent further said that it was a difficult moment, she stated, the abortion was followed by;

Florence: "…….severe pain with heavy bleeding yet I had nothing to eat or drink"
Angela: After two days of taking the herbs, heavy drops of blood started coming out. I felt half-conscious for part of the day for about 3 hours.

Such was the situation where the mother was at great risk, no food and yet lost a lot of blood in the bleeding thereafter the abortion.

Hostile health workers

In relation to the above, another respondent noted that she used local herbs like Erlangea tomentosa and Commelinaceae. The respondents also observed that many times the health workers were so hostile and abused them but finally were helpful. As a result of the abortion, a respondent noted that;

> *Harriet: "They washed inside my uterus and gave me several tablets".*

From the above, it can be asserted that health workers were very vital much as they were most times hostile to the women intending to induce abortions

4.4 The short and long term lived experiences after the induced abortion among women who had an induced abortion in Rakai district

The study also looked into the long term and the short term lived experiences after the induced abortion. Women who induce abortion experience some conditions immediately after the abortions, and these vary from woman to woman. The section below narrates the findings on such lived experiences;

4.4.1 Short term lived experiences after the induced abortion

The study found out that some women never regretted about the loss the pregnancy in the first few moments because their decision to abort was influenced by emotions of frustration and stress from the men responsible. This reflects that women were driven by emotion rather than intuition to make their decisions.

Separations

In some cases, abortions resulted in separation of the partners. This was evident when there was no consensus on whether or not to abort. A certain lady who was forced by the boyfriend to abort the pregnancy against her wish noted that,

> *Hope: "This time round we had to separate. I imagined, if this boy loved me why did he insist on abortion".*

> *Ruth: "We ended the relationship since the boyfriend got to know that my reason for aborting was that my family would not accept him" …… I can't imagine what he told his family because some how they got to know I was carrying his pregnancy and later no child was coming forth.*
>
> *Angela: Remember he got to know about my abortion and stayed with me any way since I was partly the source of his survival. Deep down, he was annoyed. When he got a chance of a good job, he poured all his bitterness to my ears. I cried and begged for forgiveness. He left me and married another woman and they are very rich now*

Loss of family bonding

Another immediate experience for women who induced abortions was that they were rejected by their families and felt they belonged now where. A young lady who was in her early 20's said,

> *Flavia: "My daddy got to know about my induced abortion and he sent me away from home ...People just throw me away that am a spoilt child"*

From the above, it is indicated that this lady and many others were discarded as wrong elements and instead of being given emotional support, they were instead driven into a sorrier state and feeling of isolation. This can even make other women who abort continue to hide and suffer silently as they are aware that society will only reject them and not respect their feelings and conditions.

Loss of studies

For women who were in school, induced abortions were followed by loss studies, they in most cases failed to make it back to school, yet in the first place the reason to induce abortion was to ensure continuation of studying. A former school girl, a women in her late 20"s who dropped out of school after an abortion thus narrated,

> *Flavia: "…it was difficult for me to decide between delivering the baby and inducing the abortion but I decided in pain and induced it in order to go back to school but, unfortunately, I lost both the baby and studies."*

Guilt and anger

There were feelings of guilt and anger after the abortions. A lady confessed,

> *Patricia:"I was schooling and my future was lost because of that induced abortion yet my parents had little money and I was greatly challenged. My life was too challenged after the abortion compared to the life I had before and even my parents were greatly annoyed with me."*
>
> *Hope: "I felt I had done a terrible thing to my family. I fill I am a bad girl in my family"*

Women seemed to have developed a guilty conscience. In this case some mothers looked at themselves as murderers. A young lady who had failed to get pregnant for more than two years ever since she induced an abortion thought that God had punished her for being a murderer, she thus said,

> *Mary: "I see myself as a murderer, May be I am a murderer?"*
> *Irene: I feel guilty up to now. I think I deserve to repent every day for what I did.*
> *I feel my children may hate me for killing one of them.*
> *Angela: I must even have been cursed.*

Fear of being revealed

Here, mothers revealed that they lived in constant fear that may be one day someone will uncover their secrets and expose them. The study also found out that having an abortion made the mothers feel so ashamed of themselves even when no one knew about this; others felt very shy thinking someone might have known but opted to be silent.

From the above, we see double jeopardy, doing an abortion, leading to loss of both the baby and studies. Many of the women confessed that they could not continue schooling and imagined it would have been better if they carried their pregnancies and produced their children.

Regret

The study also found out that women who had induced abortion were regretting much, were in agony and felt they did something very bad. Many of them wished they could reverse their decision; however, it was too late. One respondent explained,

> *Mary: "I always regret. I am in agony, and always in worries, wondering what I was up to when I induced an abortion."*

From the above, respondents indicated that they were not happy with their own decision to induce an abortion.

Shifting blame to men

The study further revealed that in the short run, mothers blamed their situation on men; they felt men were very bad people who had forced them to act against their conscience and thus felt like not associating with men any more for relationship issues.

Stigma

One lady who had been abandoned by the husband before aborting submitted that,

> *Florence: "I hate my whole life, got worries, hate men and everybody."*

Such expressed indicate an aggrieved woman, who hates herself and those around. Such emotions if left unattended to can lead to crime like homicide and breed other vices like abusing drugs, violence among others.

The religious people seemed not to have been supportive to help them out of their situation as one of the respondents indicated,

> *Flavia: "….the few times I have gone to church after the abortion, they talk about it so much!!!So now I don't want to go to church …I just pray from here."*

This indicates that she was disappointed by religious leaders who got to know about her abortion pinning her instead of helping her out.

Abortion killed their confidence in public and thus they could not stand before any group of people publically, thinking someone could have known and decide to break their secret in public, as such they avoided public places for as long as it was possible. This was a case of self-isolation. Some even feared their own relatives, thinking somehow they might have known what they did.

Sickness

After the abortion process, women also revealed that their health was negatively affected. The effects ranged from physical to psychological and financial. Several ladies confessed how they became sick on and off, lost weight and got wasted, some had to run away from where they were known. One of the participants confessed that she bled to near death as the bleeding continued for more than a month after the induced abortion.

> *Phiona: It was a terrible experience….Too much bleeding, anaemia, weight loss, sickness on and off and a string of other problems followed my unsafe abortion.*

Other cases reported were that the mothers got wasted, had too much pain, bleeding. Others became very weak and were always sick after the action of abortion. This was further aggravated by the use of local herbs only to seek proper medical attention when their life was threatened to near death.

Loss of uterus

Two women confessed to have lost their uterus as they were removed later since they were rotting. "I almost lost my life due to a rotting uterus", said one of the respondents. A married woman who had gotten pregnant outside marriage and decided to induce an abortion confessed that,

> *Racheal: "....I got complications in the uterus. So, evacuation was done and I was given some drugs to help me squeeze out remains and blood. I bled, got severe abdominal pain, shame and fear amongst friends and also my husband. I almost lost my life. I almost lost my marriage"*

Stress

Initially, many of the mothers thought that once they abort, they would feel free. This was however not realized as many of them were instead more stressed thereafter. One of the participants noted that she was so stressed and anxious after the abortion.

Weight loss

One of the respondents revealed,

> *Hajara: "…..even my friends seemed so suspicious of the way I looked because I changed a lot –lost a lot of weight, darkened the skin and yet I was originally very brown; so I think they knew though they didn't tell me. I feel guilty that they were backbiting me, I suspected."*

From the above, some women went through a period of uncertainty, not sure what people around them thought about them and how they would react.

Rationalization

On the other hand, some mothers were not bothered about their action of inducing an abortion. They were confident they did the right thing in the circumstances as they unfolded. One of the respondents, a woman in her 30's said,

> *Harriet: "…I don't feel much loss because the baby had no body parts, it was very young and only clots of blood were seen, so I don't really imagine how that baby was."*

Detachment from religion

However, some women were concerned about their attachment with religion vis-a-vis their actions of inducing abortions. One of respondents commented,

> *Harriet: "…. but my religion as a catholic doesn't accept what I did and I really feel bad about it and I beg for forgiveness from my God because I honestly made a mistake and am guilty."*
> *Annet: I imagine if I died today, what will I answer God, that I killed an innocent baby, why?? God has all the rights to punish wrong doers like me. I even feel I am a misfit in church.*
> *Barbra: I wonder if God will ever forgive me for this.*

From the above, it can be inferred that reverence to religion was not enough to deter abortion; it was rather used for purposes of reflection, an unfortunate situation of acting before reflecting on the action.

Religion was also featured in the confessions of the women who had induced abortions. There were several confessions from the participants as narrated here below;

> *Mary: "May be God punished me by not getting other children".*

Another respondent said, "

> *Flavia: "My catholic faith doesn't accept what I did, so I fear going to church, I feel I sinned against my God."*

Still another respondent confessed,

> *Patricia: "My church and religion is not in line with the decision I took to induce the abortion and even I feel unworthy staying among my people and community. I regret while I did this".*

A saved, married woman in her 30"s lamented,

> *Racheal: " I am a saved woman and my religion is completely against inducing abortions because it means someone has killed a person, even my pastor doesn't know about it. I kept it as a great secret."*

A university student who had an induced abortion also reacted that,

> *Hajara: "As far as my Muslim faith is, it wasn't good at all and I feel I murdered someone and I sinned against Allah. I even feel ashamed and this reduces the times I go for prayers."*

According to the above findings, there is no religion which supports induced abortions. The study also reveals that people were concerned about how religion and God would judge them. They recognized that they had done something not acceptable to their faith.

The study found out that the hardest parts on looking back on the decision to have an abortion were deciding in anger and what could happen immediately and whether the issue would remain a secret. Many reported that the anger was gone after the abortion. Still, many of them successfully kept it as a secret and nobody knew about their induced abortion.

From the above narrations, it can be asserted that the lived experiences of mothers after induced abortions in the short run included emotional, psychological, financial, relationship issues, social- religious issues among others. The experiences were largely undesirable and regrettable in nature, with a few satisfying experiences being lived.

Satisfaction

Much as most experiences were negative, in the short run some respondents indicated that they felt satisfied and that they had done the right thing to abort given their situation. One respondent indicated,

> *Grace: I believed then that I had the right to make that choice since it was in my view concerning my life. I didn't care at the moment what could happen to the baby.*

4.4.2 Long term lived experiences after the induced abortion

Mothers may have experiences they undergo even though long after they induced the abortions. These were explored among the mothers in Rakai and the findings on these long term experiences are narrated here below;

Feeling sorry

Even after a long period, some women who had aborted revealed that they still felt sorry about what they did. Such a feeling was associated with other problems of losing confidence, feeling less human and so forth. One lady clearly indicated that,

> *Adrine: "I had an abortion when I was 21 years old. It was 10 weeks, and I have been sorry about it ever since.*

Repeated habit

There was a case of a respondent who revealed that for her, abortion had become part of her life. She also had developed very bad drinking habits just to make sure she forgets the abortion

experience only to become pregnant again a result of irresponsible drinking where she had multiple relationships; she revealed,

> *Nambi: "A year later, I developed despair that was only inflated by drinking alcohol. I again aborted twice, first at three months, then at 5 months in a space of two years".*

Failure to conceive

The study found out that some mothers had difficulty conceiving after an induced abortion. Others failed completely to conceive again. This is a point when they became very disappointed of having wasted the "few" chances they had to conceive. This was followed by great agony, regret, confusion and self-blaming. A lady who aborted and later got a new husband, waiting for official marriage after conceiving had tried for over a year in vain. Her proposed formal marriage was becoming impossible due to failure to show the current boyfriend signs of being able to conceive. She thus lamented,

> *Mary: "……got married and no child at all. I am worried most of the time. I think God had created only those two children in my womb that I aborted!!!*

She then cried, and continued,

> *"I have deep thoughts about my aborted children. I cry in privacy and feel too bad up to today……. I am in grate agony, may be God had created only those two children for me, no baby, my marriage is going to break down because no baby"…she then cried.*

Another respondent, a lady who was about 26 years old had to visibly regret as she narrated,

> *Florence: "….feel offended and depressed. When I see a lady breast feeding a baby, I greatly regret and imagine myself where my child would have reached, would be grown. I feel guilty of the child for whom I induced the abortion. Now I got a man and no child for a full year now!! So am confused. I want a baby but in vain. Sometimes I get great pain and I see as if my child is asking me "why did you do this mummy"*
>
> *Irene: No man can marry me since I can't produce. It is all rubbish and rubbish.*

From the above, the study found out that women regretted their actions of inducing abortions, more especially when associated with failure to conceive again. Several other women had related

confessions of doubting whether they will ever conceive, even for some the uterus were removed, making it practically impossible to hold pregnancies, a situation which was bound to be permanent.

Anxiety

Some respondents had anxiety over a long period of time. One lady thus confessed,

> *Nambi: "I have tried anti-anxiety medications but my situation is not improving. There is a time when I attempted suicide"…… I use alcohol to help me forget my dirty past, but whenever I am sober, thoughts of my unserious acts of abortion and the lives I denied a chance to live come up.*

Failure to normalize life

The study also found out that relationships broke up after the abortion and life was never the same again. While to some the motive was to retain their jobs, falling sick all the time after an abortion made them instead loose the jobs they wanted to protect in the first place. One of the participants revealed,

> *Harriet: "I honestly, feel my life is not the same as usual, I frequently fall sick, stress, weak generally I am not good. Right now, am regretting why I induced that abortion, I wish I bared it all and I delivered that child because I lost the baby, job, I am sickly and even the man who was supporting me, dropped me."*

Related to the above, another woman confessed,

> *Patricia: "I don't even wish to deliver soon, I need to first settle and I feel bad to see children in my aborted child's age."*

In addition, another lady revealed,

> *Nambi: "my life is still mixed up, largely with regrets".*

Guilty feeling

Another confession was from a perceiving now barren woman after the induced abortion who, while crying revealed,

> *Racheal: "I feel guilty as if I murdered someone. when I see children in the age of my induced abortion, I feel like I regret that I wish I hadn't induced that abortion, could be my child would have been alive like those children."*

The interaction with another respondent in the study indicated that women regretted in the long run.

> *Racheal: "Talking about my induced abortion experience with you was not easy at first, but I again thought that you being a professional; may be of help to calm me down. And right now I feel relieved at least because of the guidance you have given me, because it has been really hurting me so much.*

Another respondent indicated,

> *Hajara: "Today I feel relieved of the burden of the sin I did so I am a bit free because I have shared with you today. All along it has been between me and the medic who helped me to induce the abortion because I wouldn't even tell any friend about it."*

Other respondents revealed grief in their hearts. For instance,

> *Grace: About a year later, my heart broke. I was so overcome with grief. How could I have taken the life of my unborn child?"*

Clearly Grace was not happy with her decision to abort even after a year elapsing.

> *Barbra: "I however sometimes miss my baby since it would be playing around and asking me funny questions just like other babies. I really miss my baby. No matter how many children I will have, I will never forget this innocent child…I…destroyed"*

Auditory hallucinations

Another lady, confessed,

> *Hajara: "I am feeling guilty because I killed someone, it hurts me so much. I get voices asking me why did I induce that abortion, I would have left the baby to grow but I didn't need the baby and I already induced the abortion. I feel my baby would have grown by now. Anyway, I got confused of where I would have put the baby because the man had refused and my parent didn't know and I didn't want them to know at all."*

Depression

In the long-term, many of the mothers were not happy generally as they felt there was nothing that would be reversed. It was more depressing to imagine how old their children would be if they did not abort. From the above, mothers were not concerned about the actually abortion generally, but they key issue was failing to conceive thus leading them to reflect on what they

had done to induce abortions. This could also point to the fact that, if the mothers had no challenges of conceiving, may be they would not regret much.

> *Adrine: This abortion has made me get depressions for years. Life has never been the same again.*

Feeling great loss

Some women however felt that they had not lost it all as they lost the children but were able to continue with their studies. A University graduate revealed that,

> *Hajara: ".... Honestly, I feel saying inducing an abortion means leading someone to death. And now I feel wishing to deliver a baby because I have finished my studies and my parents are happy with me. I see children around and I feel bad, I imagine how mine would have been now".*
> *Phiona:" I have no stable income, my boyfriend went, my baby is gone. I have never stabilized since then".*

From the above, this woman has two sides of emotions, one where she is satisfied and the other side where she misses her child who was induced into abortion. Finally, she advised women to avoid unplanned pregnancies.

Living in fear

A couple of ladies indicated that after abortion, they leave in fear. Some indicated that they feared what would happen if society gets to know what they did. Others were now schooling but imagined what if they fail to get pregnant again. This was indicated by a lady,

> *Hope: "I not sure if I will give birth, it also scares me, what if my sexuality was messed up in the process of abortion. I even fail to eat when I think about such"*

Feeling a society misfit

The study also found out that the society largely condemns abortion, so there is nothing much mothers who aborted would expect from the society in its current ideological setting. In this case, society includes the immediate family, the religious and the friends. One of the respondents, a young lady in her early 20's who dropped out of secondary school after an induced abortion commented that,

> *Flavia: "I feel disgraced, segregated and hated. This should not have been the reaction of my immediate family. I advise girls to avoid admiring so much because I got to this situation because I wanted a lot of money. Also parents should be forgiving and understanding. They should guide us and not talk about us any how because we are still their children".*

From the above confession, the study indicates that the society only blamed these women who induced abortions as means to deter other women from doing such. However, this act, created feelings of segregation, anger and lack of belonging to the women.

Self-condemnation

Many of the women lived a life of being judged as wrong doers, killers, murderers and sorts of blemish and judgment. From this, the study also explored what these women who had induced abortions were reflecting on the experience they were given to talk about the induced abortions.

4.4.3 Advice to fellow women

The study hypothesized that once women talk about their abortion experience; it would create some relief in their lives. This was proved to be true as many of the women were happy to have talked about their experience, in a private and professional setting. The results on how women felt having talked about the abortion experience are expressed here below:

Get abortion service from a trained health worker

Women expressed that they would advise their fellow women to opt for family planning, notwithstanding its limitations, as a means of avoiding unwanted pregnancies other than "killing" the unborn babies. One respondent said,

> *Mary: " I advise women and girls to use family planning methods from good health facilities and trained health personnel.*

Another respondent said,

> *Patricia: "I advise girls to stay focused on their studies to avoid unwanted pregnancies.*
> *Irene: Use family planning and especially methods that prevent conceiving other than abortion.*

In addition, other respondents were furious that people were only judgmental other than being supportive. They were happy that in this study, the interaction was not judgmental and were thus happy. A respondent was happy and said,

> *Mary: "Today I have at least tried to talk about my situation and you have not judged me, so I feel grateful for the counseling you have given me and I wish you even come back and talk to me because I could not talk about it with anyone else."*

Related to the above, a respondent was relieved and happy for not being judged. She thus said,

> *Flavia: "It is difficult for to talk about my situation to anybody, so am not free to say anything about my induced abortion but for you, I have got trust and counseling. Very few would not be judgmental, most would judge me badly but today I have got relieved and comfort after talking to you for a while."*

Still, through experience, the mothers seemed to hate abortion with all their passion. This indicates they were living a life of regretting and wishing to reverse the irreversible and thus advocated for stopping such acts. A mother indicated,

> *Florence: "Today talking to you about my induced abortion was not easy at all, because whenever I talk about it, I remember my child that I aborted. So I advise women and girls, if they can't avoid those pregnancies through using family planning methods from trained health workers, then they should avoid sexual relationships …."*

Related to the above, women advised that use of family planning would be essential in avoiding unwanted pregnancies, particularly, and the use of condoms. A mother indicated,

> *Hajara: "My advice to women and young girls is that, they should use family planning if at all they can't avoid men so that they don't go through what I went through, they should avoid these unwanted pregnancies that will force them to induce abortion and can also use condoms.*

There were more signs of relief, as many mothers were heavily burden by the acts of abortion and they could not talk to anyone. Respondents were thus relieved of such burden of having no one to talk to, as a participant indicated,

The study also premises that there are many such mothers who have no one to talk to and thus live a life full of heavy psychological burdens they cannot drop since there is no one to talk to.

The study also looked at how the life of the mothers had changed after the induced abortion. The study revealed that there was a feeling of self-pity whenever they could see other children and they imagined how their aborted children would be.

Mothers also revealed that from their experience, they could never recommend someone to induce an abortion because many said they almost lost their lives and some revealed they knew mothers who had died in the process or immediately after and this kept tormenting them, seeing themselves as mere survivors.

Building stable relationship

Having gone through the abortion experience, some mothers had composed themselves and were concentrating on building stable relationship with their families and avoiding men for a while.

Some mothers also confessed how they disliked family planning and opted to avoid men. Whether this is a practical strategy was not established.

Hard work

One of the ladies noted that the reason for her abortion was largely to continue with education. Having done this, she ensured that she achieved the best out of her education to compensate for her lost child. This was a positive development since it became an impetus for hardwork. Se thus confessed,

> *Assumptah: Whenever I went to school, I worked so hard looking at what I sacrificed to be at school, it kept me work so hard to achieve the best possible.*

Better survival strategies

Other women looked at being self-sustaining having aborted due to failure or perceived failure to sustain themselves. To avoid repeating the abortions, women were strategizing to become self-reliant financially by establishing small businesses for tailoring, restaurants and retail shops

according to how they could afford. In their confession, this would make them support their pregnancies even when men abandoned them.

Finally, some of the causes of abortion were related to unfaithfulness on the part of married women, and on this, this woman, particularly recommended that women (and men) should stay faithful as a means to deter unwanted and unplanned pregnancies and the attempts to induce abortions.

Generally, the long term lived experiences were full of reflections, some positive and others negative. Concentration was on how to re-integrate in society and avoiding past mistakes while advising those who have never fell victims to stay aware and focused.

CHAPTER FIVE

DISCUSSION OF FINDINGS

5.1 Introduction

This chapter contains the discussion, conclusion and recommendation. The presentation follows the study objectives which include; the lived experiences of women who had induced abortion in Rakai District on learning about the aborted pregnancy; lived experiences of the process of inducing an abortion among women who underwent induced abortion in Rakai District; and the short and long term lived experiences after the induced abortion among women who had an induced abortion in Rakai district.

5.2 Discussion

5.2.1 The lived experiences of women who had induced abortion in Rakai District on learning about the aborted pregnancy

The study found out that most of the mothers did not plan for the pregnancies which were later to become induced abortions. Many of them noted that pregnancy was the last thing they expected and lack of readiness pushed them to abort. This closely relates to what Welter (2015) noted citing that during their lifetime, many women will experience an unplanned and or unwanted pregnancy that invariably leads to a reproductive decision-making tree that may include abortion. There were elements of unfaithfulness and unwanted pregnancies given the circumstances which forced mothers to abort against their will.

In relation to literature, Nader, Blandino and Maciel (2007) in their study in Brazil show that most women who had induced abortion had unplanned pregnancy. This same situation was

seen to have happened to many women in Rakai. There were several other confessions of not being ready and a feeling of being caught unaware.

Sell et al, (2015) points out that fear of the reaction of parents or disappointing them was one of the driving issues inducing abortions, similar to what is seen in the cited case above. It thus follows that parents somehow played a role in influencing induced abortions indirectly. Many mothers on learning about their state of being pregnant were caught unaware. These findings are closely linked to previous research as documented by Major et al.(2000) who posited that a pre-abortion history of depression was strongly associated with post-abortion depression, low self-esteem and negative abortion outcomes.

The study found out that the most influential people in the decision of whether or not to abort were the peers. Parents were rather seen as being totally unaware of what their children (women who aborted) were going through. Grandparents were also consulted basing on the account that they had experience in local herbs; and also partly because parents of the pregnant women would be so hostile and uncooperative. The study also reveals that friends were very instrumental in influencing induced abortions. This finding is in support of what Appiah-Agyekum (2014) had earlier found out that 26.1% of the women or girls who induced abortions did so under direct experience and influence from peers - friends, course-mates, roommates.

The study also found out that there were various reasons that emerged to have encouraged mothers to think about inducing abortions as soon as they learnt that they were pregnant. Some were entirely upon the discretion of the mothers while others were circumstantial and others were perceived to be beyond the control of the mother involved.

Relationship complexities were some of the key factors precipitating induced abortions. Many of the mothers had a troubled relationship. This also relates to what other scholars had found out

earlier, for instance, Sell et al. (2015) noted that relationship complexities and the desire to remain in school was a key reason for inducing abortions. Women revealed that being unfaithful culminated into not being ready for the pregnancy and were not ready to be ashamed. So there was a mix of anger and unfaithfulness in the scenarios explained.

Women also looked into their financial needs and how they could be able to meet them as they contemplated aborting.

The instance of pregnancy outside marriage closely relates to Neema (2012) who said that for young girls who often fall pregnant outside marriage, the usual easiest and best option for them is to terminate the pregnancy regardless of the complications just to avoid facing the judgment from their families, friends and the community as a whole. Lack of support from the spouse was on the minds of women, finally culminating into the decision to abort. Financial constraints were part of the reasons for mothers to think about inducing abortions. Similarly, socioeconomic factors like unemployment or fear of losing their jobs were cited by Sell et al., (2015) in their study.

Some women looked at the future of their studies as being of paramount importance and as such, they would rather abort than carry on the pregnancy. It was natural for such mothers to opt for inducing and abortion. Various women expressed that the need to continue with education propelled them to induce abortion. This directly agrees with what Finer et al.(2005) found out, where it was noted that induced abortion decision-making among 1,209 women in U.S. clinics were due to the desire to maintain education or schooling.

There were some few cases where abortion was used as a family planning method, but even then it was not a result of mutual agreement. Still, there would be better options like contraception like use of pills and condoms other than the risky abortions. This relates to allegations women

gave in previous studies where they blamed their decision to abort on limited access to family planning services (Sell et al. (2015).

The study revealed that at the time, all the reflections of women were on the circumstances surrounding their pregnancy rather than on the baby being terminated. At the time of abortion, with only one exception of the cheating married woman, the mothers were extremely angered and disappointed by the fathers of their pregnancies. These are some of the examples among the many who were a reaction out of anger. Parents were perceived and indeed proved to be harsh to their children who got pregnant. To escape from such harsh treatment, young ladies who became pregnant decided to induce abortions before their parents would know. Unfortunately, many of them were known since the consequences of the induced abortion proved to be life threatening and somehow parents got know. The suspicion that parents would not be helpful was on the minds of many of the young ladies who finally induced the abortions.

The study also revealed that the society was non supportive to the women and this served to encourage them to induce abortions other than be ashamed to carry pregnancies outside marriage or prematurely. The study found out that women would rather abort secretly. The conscience of the mothers was such that they felt induced abortion was equivalent to sin and murder, was described as unreligious and terrible, among other words. This finding can also be said to have re-emphasized what Welter (2015) had earlier noted that culture and religion among young Mexican-American women played an important role in the decision-making processes relating to abortion. Similarly, in Rakai, religion somehow featured only that it made the mothers do their induced abortions in hiding.

5.2.2 The lived experiences of the process of inducing an abortion among women who underwent induced abortion in Rakai District

The study revealed that the process of inducing abortion was done mostly using local means and such cases were referred later to professional clinics when the life of the aborting mother was in danger. This served to cause more harm and longer healing process. There are also various scholars documenting about the process as narrated in the section following hereafter. Various other findings were revealed to have occurred in the process of inducing abortions as detailed in the narration that follows;

Various local herbs were used, usually after consulting peers and old women. The most common herbs used were *majaani* (concentrated tea leaves mixed with hot water); "*ekiwoko", roots of sugar canes, "etwaata" and "kisuula" and "ennanda".* There is also a linkage with literature where it is noted that using traditional methods of contraception were associated with a higher likelihood of a repeat of induced abortion (Maina, Mutua and Sidze (2015). Literature however does not explain how this happens. In the findings however, the study found out that traditional medicine was a readily available option, at no cost and thus would encourage disgruntled mothers to induce abortions.

Another respondent observed that local herbs failed. Later she got assistance from trained health workers; however, she got severely sick and weak. Such herbs were used without any professional prescription. The most profound reasons for using such were due to cost implications as most of the mothers were not employed, some were housewives, others were students and thus could not afford professional charges. Besides, abortion is still illegal in Uganda thus going to government facilities for such services would jeopardize the plans of the mother intending to induce the abortion. The only choice left was to resort to such unregulated,

non-supervised and non-recommended means of inducing abortions. This finding agrees with Rasch et al.(2014) who conclude that persistent use of these unregulated methods reflect the lack of easy alternative abortion options and signify the need for abortion policy which will pave the way for safer abortion services. The findings however contrast with what was found in Zanzibar where women terminated the pregnancy without physical sequel or need for PAC. It is possible that women who had a doctor terminate their pregnancies were given prophylactic antibiotics, thus reducing the risk of infection and potentially seeking formal PAC at the hospital (Norris, Harrington, Grossman et al., 2016)

Due to use of largely unprofessional means, abortion relied on only guess work and experience. As a result, induced abortions were largely half-successful. Many described the process as being terrible. Among the complications was severe bleeding, ill health, abdominal pain, baby not coming out well leading to need to "wash" the uterus, in some instances uterus were removed leading to secondary barrenness.

The process of abortion exposed mothers to great risks as many never had proper care since the whole process was done in hiding. Some mothers confessed lacking food during the preparations stages for abortion yet they lost too much blood. In this case, the mother decided to do the abortion without telling any family member. In the process, this caused too much suffering. This closely relates to what was highlighted by other studies that the isolation of undergoing induced abortion and the concerns to conceal it from others reflects a guilt feeling and thus negative perception and experience (Alex &Hammarström, 2004).

There were elements of hostility in the process where health workers intervened to save the threatened lives. This was due to the fact that mothers first did their abortions in privacy and only

came at a stage where their lives were in danger. This finding also relates to Felding et al, (2002) who note that participants compared positive experiences of treatment by professionals providing medical induced abortion in clinical trials with professionals' negative attitudes and impersonal clinic settings in ordinary services. In the case of Rakai, mothers complained that the attitude of health workers was more of a deterring factor to them to seek help and thus worsened their experience.

From the above, it can be asserted that health workers were very vital much as they were most times hostile to the women intending to induce abortions. This finding relates with what literature documents that involvement of professionals is necessary to make the process less risky. Katrina et al. (2011) note that the procedure was made more positive by nonjudgmental staff who conveyed genuine concerns, the kindness of the staff especially the nurses who were nonjudgmental, very supportive, and some felt the absence of their families was made up well by the friendliness of the nurse.

Some mothers made enough preparations for the process of inducing abortions, including making prior arrangements with the health workers. This somehow reduced the risk in the process. The process of induced abortion was depicted as potentially risky, whether done professionally or locally. However, the involvement of professionals served to reduce the gravity of the risks associated with the process of inducing abortions.

5.2.3 The short and long term lived experiences after the induced abortion among women who had an induced abortion in Rakai district.

The study revealed that after the process of inducing the abortion, mothers go through a series of experiences, some negative some positive, some are experienced in the short term while others emerge later on in their lives. The section below discusses such experiences.

5.2.3.1 Short term lived experiences after the induced abortion

The study revealed that some women never regretted about the loss the pregnancy in the first few moments as they had been frustrated by their spouses and felt they were freed from stress.

Another immediate experience is that the families of women rejected them and thus lost a sense of belonging. The experience was such that the women were isolated and discarded as wrong elements that were not having positive contribution to society other than spoiling the young girls. The study thus revealed that women who induced abortions were in hiding and suffered silently well aware that society would only hold them with low esteem. This finding relates and agree with what researcher like Rees and Sabia (2007); Pedersen (2008) found out that there was a correlation between abortion and depression along with other outcomes such as anxiety disorders or substance abuse disorders. Finally, Kersting, Kroker, Steinhard et al. (2009) found out that there was a correlation between abortion and loss of self-esteem alone.

The study revealed that almost all school going women or girls lost their studies owing to inducing abortions. This was partly because they fell sick on and off and partly because their sponsors could not help sponsoring such “spoilt” girls. Losing both, a pregnancy through an abortion and stopping studying, was such a regrettable experience gone through by many of the

formerly school going girls who induced abortions. These findings seem not to agree with what other researchers found out earlier. For instance, Broen et al., 2005) and that abortion is highly related to important positive life outcomes concerning education, career trajectory, and income level as compared to women who carry unplanned pregnancies to term (Fergusson, Boden & Horwood, 2007). However, in Rakai, most of the mothers involved found themselves unable to complete the studies. Broen et al., 2005) and that abortion is highly related to important positive life outcomes concerning education, career trajectory, and income level as compared to women who carry unplanned pregnancies to term (Fergusson, Boden & Horwood, 2007). Similarly Bender and Geirrson (2004) note that giving birth to an unplanned pregnancy, especially for very young or unmarried women, seriously restricts educational and professional opportunities.

After abortion, women went through a period of regretting much, being in agony and feeling guilty that they did something very bad. The study revealed that for many women, it does psychologically not deserve to live a life of regret as this can even bring physiological complexities, but many of the women were seen to have lived in such a state of life after the induced abortion. In relation to this finding, Machado et al. (2016) note that the immediate experiences after the abortion were feelings of sadness and emotional pain. Some women reportedly have strange feelings for killing a life. Others are filled with a sense of emptiness especially when passing through the middle of a ward with mothers having their babies.

In the short run, mothers blamed their situation on men. This was due to the fact that if men had not abandoned them, many confessed they would have carried on their pregnancies. They thus lived in a life of denial as they felt men were very bad people who had forced

them indirectly to induce the abortions, which some treasured initially. It was clear that women in such a state were aggrieved, were annoyed by both themselves and those around them. The study just assumes that many such women could be existing and this is likely to cause more psychological problems. This serious emotional state can be compared with what previous studies have document. For instance, Shellenberg, et al. (2014) note that much less has been studied on stigma related to abortions. Besides the little literature present on the abortion stigma, it has been hypothesized that the stigma following induced abortion affects women negatively, where this include their mental health as well as leading to cognitive and emotional implications of concealment (Major, et al., 1999; Major, B; Appelbaum, M; Beckman, L; Dutton, M.A; Russo, N.F; West, C, 2009). As for this study, there seems to be evidence that inducing abortion is associated with psychological problems, which may feature even in the long term.

After the abortion process, women also revealed that their health was negatively affected. Majority revealed that life after induced abortion was characterized by frequent sickness, weight loss and wasting, self-isolation by running away from where they were known. There were also reports of bleeding that continued for more than a month after the induced abortion. In extreme cases there was loss of the uterus as for them they were removed due to rotting. This means that they could not have children any more

The study also revealed that contrary to what mothers thought, abortion came with more stress than it had actually intended to reduce. Many mothers were seen to have gone through a stressful period after induced abortion. The study also found out that mothers felt ashamed of themselves. Many suspected that there was a likelihood that their secrets leaked. Others felt very shy thinking

someone might have known but opted to be silent. In extreme cases, some women even feared their own family members and could not trust them. This was revealed by many of the mothers. This indicates a period when the society was not supportive and women felt that they were not as normal as other women given their act of inducing abortions. In case where women failed to conceive, the mothers thought God had punished them in advance thus feeling self-accusation and deep regrets. Women in various cases accused themselves of being murderers and this served to further distance them from main stream society and feel socially detached. This finding relates to what Agrawal, Praween and Seyeed (2012) note that abortion subject's women to pain, fear, guilt and anxiety much as the procedure was perceived as an act of grotesque and violent death.

The study however revealed that induced abortion was not entirely leading to negative results. There were some positives where mothers felt they did a right thing to induce the abortion given the circumstances. In various cases women in the short run lived satisfied lives with no regrets.
In the short run, women were concerned about their attachment to various faiths and how these rated them. It was expressed by many of the respondents that somehow they had sinned and religion would judge them harshly. Various women reflected on their religion and the doctrines that follow, then their lives were surrounded by worries in relation to what they did. Mothers were pinning themselves according to what their faith dictated. This signifies that they lived in a life of self-condemnation. Women also revealed that in their lives after induced abortion, the religious people did not support them emotionally as would be expected.

Religious people were not anywhere being helpful to mothers. These findings are in agreement with what Atuyambe, Mirembe, Johansson, Kirumira,Faxlid (2005) and Singh, et al. (2010) found out that among others, the results of unwanted pregnancies and abortions

can cause a lot of hard life experiences to many young women such as being forced to quit school, having to encounter family, religious and community rejections and at worst being forced to marry or even experience very serious physical harm in some societies. The study found mothers found it hard to decide in anger, most decision were surrounded by uncertainty and thus could not stand with time as having been right. Many felt that given a chance, they would never have carried out abortions as they were convinced it was wrong.

5.2.3.2 Long term lived experiences after the induced abortion

In the long run, mothers' experiences somehow change, some towards a better state and others towards a worse state. Common among the long term experiences was the difficulty to conceive after an induced abortion. Others failed completely to conceive again, and a lot of disappointment came with such failures. Mothers went through a life of great agony, regret, confusion and self-blaming. The study revealed that mothers had their marriages being threatened due to failure to produce or at least show signs of pregnancy.

The study thus revealed that one of the lived long term lives was associated with failure to conceive again after an induced abortion. This finding does not agree with Gan, Zou , Wu , Li (2008) who asserted that women should be informed that there are no proven associations between induced abortion and subsequent ectopic pregnancy, placenta praevia or infertility. In Rakai, many of the women blamed their secondary barrenness to their history of induced abortion.

Several other women had related confessions of doubting whether they will ever conceive, even for some the uterus were removed, making it practically impossible to hold pregnancies, a situation which was bound to be permanent. Most of the participants lost their spouses or had

broken relationships which they were trying to make up. Others had abandoned the whole thing of relationship, an indicator that they were broken hearted by the circumstances that surrounded their induced abortions.

In the long-term, many of the mothers were not happy generally as they felt there was nothing that would be reversed. This finding agrees with what Machado et al. (2016) asserts that in the long term experiences, feelings of ambivalence were more commonly reported by women with greater religious bond, mainly Catholic .Some women attributed their success in education to the fact that they were able to induce abortions and complete the studies. However, still they had emotions of how they lost the children. The study indicated that the positive achievements were blurred by the feeling of loss for the child whose life was terminated prematurely.

The study found out that women who induced abortions were being segregated and isolated by society. Such a state of live was not admirable and was rather disturbing to the women. Women seemed to feel segregated and isolated. This finding agrees with Whereas Hessinin (2014) who earlier noted that stigma of abortion can be revealed on a number of levels, starting from individuals to systematic levels, not only here but also attached to other forms of repressions including religious, sexism, racism, cultural and socioeconomic inequalities (Hessini, 2014). This doesn't affect women's physical and mental health including disclosure decisions, but it leads also to discrimination (Major, et al., 2005).

The study indicated that the society largely blamed women who induced abortions as means to deter other women from doing such. Such actions created anger and a sense of lack of belonging to the women. The study revealed that women had no chance of disclosing or opening up and this

kept haunting their lives, holding a problem with no one to talk to. Because of this, many women involved in this study felt relieved and emotionally treated since the study gave them chance to express themselves in a free and professional atmosphere. Still, through experience, the mothers seemed to hate abortion with all their passion and thus advocated for stopping such acts. The study revealed that there is a possibility that many other women could be going through such painful states and having no one they trust to talk with about their induced abortion experiences. The study however has revealed that talking about past mischievous events provides great relief.

The study revealed that there was a feeling of self-pity on the side of mothers as when some mothers could see other children and they imagined how their aborted children would be.The mothers thus noted that they could never recommend someone to induce an abortion. Others said they even knew mothers who had died in the process or immediately after and this kept tormenting them. The finding agrees with what other researchers have documented. For instance, abortion was noted to be one of the silent killers of women, with an estimated number of women who die every year going up to 46,000 because of unsafe abortions (WHO, 2012). Shah, et al., (2009) also noted that a very large number of these women (5 million) get serious life time complications that may be either temporarily or even permanent.

Some mothers had composed themselves and were concentrating on building stable relationship with their families and avoiding men for a while. However, others also confessed how they disliked family planning and opted to avoid men. Whether this is a practical strategy was not established. This was not within the study scope, however, experience shows that except for medical reasons, very few people can totally give up with the opposite sex.

From many of the findings from various women, finance or income was key in contributing to induced abortions. On this issue, mothers seemed to have learnt a bitter lesson and many were re-

organizing themselves, making small businesses and thus trying to get predictable incomes and avoid over dependency on men, which in the first place was a cause on their vulnerability to exploitation and later failure to look after themselves.

Many confessed that they had reformed their lives and were only willing to have stable relationships and avoid mistakes like having multiple sexual partners which had led to problems. This finding agrees with literature where Bradshaw and Slade (2003) comment that even if the decision to have an abortion is complex and emotionally difficult it can also be an important inflection, and reflection, point in women's lives, and may lead to positive effects in the long-run if the experience leads women to evaluate their life, purpose, and behavior. For these women, their life was never the same as they now expressed maturity and unwillingness to repeat past mistakes.

Generally, the long term lived experiences were a combination of reflections, some positive and others negative, while initiating actions to enhance economic, religious and social lives of women who had gone through experiences of induced abortions.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

This chapter contains the conclusions on each of the study objectives and the recommendations.

6.2 Conclusions

The study concludes that women experience financial, emotional, psychological, environmental, financial, religious, and circumstantial lives before they actually decide to abort their pregnancies. The interplay of such factors greatly influence the decision of the women whether or not to carry on the pregnancy. In line with this, the study has found out that the influence of unplanned pregnancies, influence of friends, expected reaction of parents and society, the relationship with the spouse, that is, whether good or bad, financial status vis-a-vis financial help expected and the need to continue schooling were key determinants of whether or not to induce the abortion. Following these, the reaction of anger, confusion, shame, fear emerge and may lead to induced abortion.

The study concludes that the use of local herbs increases the dangers associated with induced abortion. Many of the women go for induced abortion while not prepared financial and emotionally as many do this in hiding, in hurry, in a constrained environment and worst of all under unprofessional guidance. This exacerbates the risks some of which a life threating and others are irreversible. It is therefore imperative that the process of inducing abortion be done with enough prior self-conscience and reflection under the guidance of professionals where possible.

Women live under largely negative life experiences of regretting, guilt, self – blaming, denial, irreversible emotions of likening themselves to murderers, being dissociated from society;

feeling betrayed when their secrets leak, feeling less important, and emptiness after failing to conceive again. However, there some cases where women felt satisfied in circumstances where they were able to conceive again, to complete their studies, to hide their abortion completely from every one apart from the medic who helped them. Majority of the women however, were seen not to approve what they did and regretted and wished it had not happened and thus recommended that women should avoid any circumstances leading to induced abortion.

6.3 Recommendations

To Ministry of Health

The ministry should consider revising policies to allowing women with exception conditions pertaining to especially carrying a pregnancy as a result of rape, not knowing the father of the child to carry out abortion.

The Ministry of Health should improve on the availability and accessibility of health care to rural women as they are economically constrained to afford private medical care.

Policy makers

Law enforcement authorities need to become more active and willing to help mothers who forward cases of men abandoning them while pregnant. This would act as a repressive measure to discipline irresponsible men who force women indirectly to induce abortions having abandoned them.

The legal fraternity should consider enacting laws which may permit under special circumstances women to induce abortions in a safe setting other than doing it in hiding which has been exposed

to lead to death and sometimes irreversible negative health outcomes like loss of uterus and secondary bareness.

Health practitioners

Health workers and women in child bearing age need to work together in forum discussing openly how to control unplanned pregnancies. Such forums can be made in planned outreaches at the grassroots. Through such forums, women will learn from experience of others that becoming pregnant, whether planned or unplanned should not be taken as a curse and avoid any mentality of inducing abortions.

The civil society

The society, particularly religious people need to appreciate that induced abortion in a deeply entrenched habit that needs concerted effort to address other than just blaming and isolating victims. Religious leaders therefore and elders need to talk to women in a friendly and constructive way that creates social cohesion, harmony and learning as well as re-learning from experience.

Parents have been noted to be very harsh and thus promoting women to hide their relationship affairs including pregnancies' and induced abortions. The study suggests that parents would rather talk to their daughters and provide guidance as and when needed other than distancing themselves from reality.

The religious leaders etc. as per your findings

Religious leaders should morally support women other than segregating them due to abortion related issues. They should in addition provide adhoc counseling and spiritual rehabilitation to mothers who have family related issues to ensure that they are deterred from aborting.

Mothers and girls

Mothers should be given pre-natal counseling to prepare them for any eventualities and openly find out what drives them to induce abortions.

School going children should be educated about contraception and be given real contraception before they become pregnant while still schooling. This should however be given following their own choice, thus they should only be convinced and told about the benefits of protecting themselves against unwanted pregnancies as opposed to forcing them since this would be a violation of their human rights and medical ethics.

Women who for unavoidable reasons decide to induce abortions should do this after enough preparations, with the help of trusted friend or relatives under the guidance of professionals to reduce the risks that have been seen to follow abortions. Much as it is still illegal, there is no amount which compensate a lost life.

Women should stop shying away and seek for professional counseling in case of psychological predicaments that follow induced abortions.

6.4 Suggestions for further research

Further research needs to be done on how laws can be enhanced to protect women who find themselves pregnant under complex relationships that may need induced abortions. Researcher should particularly address whether or not legalizing abortion will not lead to more unnecessary abortions.

Since Uganda is a poor country, with many women unable to afford professional health services, research needs to be done to find out how effective local medicine can be in the process of inducing abortions and other reproductive health services like contraception. Particular focus needs to be on what doses, how concentrated, how often, method storage among others. This

would help many rural mothers to at least be safer as this study has noted that almost all the herb cases were finally referred to clinics and or hospitals.

The role of society in family cohesion and sexual relationship building needs to be streamlined. The study should address how best society and religious leaders can be involved in building stable families as a key deterrence to unplanned pregnancies, relationship complexities and induced abortions.

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APPENDICES

Appendix I: Introductory Letter

lix I: Introductory Letter

Uganda
Martyrs
University

Making a difference

Faculty of Health Sciences
Telephone: 0382 410611
20th December, 2016

Re In charge of the health facility is requested to give the bearer cooperation Thanks

To: The Officer Responsible
Dear Sir/Madam,

Re: INTRODUCING NALUBEGA MARGARET JOY

This is to introduce to you Ms. **NALUBEGA MARGARET JOY** a *bona fide* student of **Uganda Martyrs University**. She is pursuing a course leading to the award of a degree in **Master** of PUBLIC HEALTH-POPULATION & REPRODUCTIVE HEALTH (MPH PRH).

She/he is currently undertaking research for her dissertation on the topic:

Lived Experiences of Women who underwent Induced Abortion:

A Case Study of Rakai District

The topic and protocol have been approved by the relevant University authorities.

Any assistance rendered to her in this respect will be much appreciated by the university.

Yours Sincerely,

For: Wonyima Isaac Okello
Supervisor/Lecturer-faculty of Health Sciences
For Faculty Approvals Committee - UMU

Appendix II: Informed Consent

Dear participant I am Margaret Joy Nalubega a student of Uganda Martyrs University, I am pursuing a course of Master's degree in public health-population and reproductive health. I am carrying out a research on Lived experiences of women who underwent abortion and am inviting you to participate in this study.

You are free to participate in this study or to withdraw from it if you so wish without affecting your relationship with the researcher. Your identity shall not be required and not be used for the purpose of this study. The interview will require about one hour of your time. During the interview feel free to ask any questions.

In case you have any questions on this study please feel free to contact my supervisor on; Email-spkatongole@gmail.com.

Study Title: Lived experiences of women who underwent induced abortion: a case study of Rakai district.

Interpretive Phenomenological study

Principal investigator: Nalubega Margaret Joy

I have read/ had the letter of information describing the study read to me and I have had the study nature explained as well. I have understood the topic and its objectives. I have received answers to questions that I asked and I therefore consent to participate in this study.

Code of Participant…….

Signature……

Date……

Name of Person Obtaining Consent……..

Signature……..

Date……

Appendix III: Recruitment Material

Dear Madam

My name is Nalubega Margaret Joy; I am a postgraduate student pursuing a Master's Degree in Public Health-Population and Reproductive Health of Uganda Martyrs University. I am doing a research study as part of the requirements of this degree and it is qualitative based investigation of the lived experiences of women in Rakai district who had an induced abortion.

I am addressing to you this letter as a major provider of healthcare/social services in Rakai district. Though it is a highly controversial issue, literature states that one-third of women will at-least have an abortion throughout their life time. The World Health Organization in 2011 reported Uganda to have an annual abortion rate of 53 abortions per 1,000 women; this number is too much when compared to the average rate of abortions that occur in Eastern Africa that only go for 36 abortions in every 1,000 women. The estimated number of illegal abortions that are performed in Uganda annually go up to 297,000 illegal abortions, where 85,000 women of the whole annual estimate is treated annually for many various complications that follow these unsafe abortions.

The main purpose of this study is to better understand the lived experiences of Rakai district women who have ever had an abortion in order to design health and social services that best meet the unique needs of these women. I would like to inform you that no such study has ever been carried out in Uganda and it will be the one of the first kind carried out in Rakai district.

I would like to organize a meeting with you if you are interested and we discuss this project. My main goal is to recruit approximately over 20 women, who are willing to participate in a confidential in-person interview with me in either Luganda or English. The participants will not be asked of their names, just as an assurance of protecting their privacy and to increase their comfort in discussing such a sensitive topic

Individuals will not have to answer any question they do not prefer and in case someone enrolled in the study feels like dropping out, she will be free with no offence accounted on her. All information obtained will be confidential and any publication that will come after this study will have to protect the client's confidentiality.

I will be so glad for your interest and help you will provide me in this study. If you're interested in supporting our efforts to better understand the needs and life experiences of the Rakai district women who have had an abortion.

I appreciate your consideration, thank you very much.

Yours sincerely,

Nalubega Margaret Joy
Postgraduate candidate, Public health-Population/Reproduction Health program
Uganda Martyrs University-Nkozi
Margaret.nalubega@stud.umu.ac.ug
Tel: 0772399605

Appendix IV: Recruitment Demographics

1. Age……
2. Childhood language……
3. Rakai district resident……
4. Marital status…….
5. Living children……
6. Abortions

i.Number of induced abortions ……

ii.Birth order of induced aborted pregnancies …….

iii.Number of children before induced abortion…….

iv.Number of children after induced abortion……

v.Induced abortion age…….

vi.Marital status at the time of induced abortion…….

vii.Where was the induced abortion management

a) Hospital……

B) Healthcenter – IV…….

-III…….

-II……

c) Private clinic/hospital……

d) Others (specify)……

viii. Time since induced abortion……

7. **QUALIFIES**

Appendix V: Interview Guide

1. Date: ……../……../…….. D/M/Y
2. What is your age? ……..
3. What is your current relationship status

a) Single
b) Married
c) Not married, but living together in a serious relationship
d) Not married, but in a serious relationship and not living together
e) Divorced
f) widowed
g) Others (specify)……

4. What is the highest grade of school attained

a) Non
b) Primary
c) Secondary O level
d) Secondary A level
e) certificate
f) diploma
g) University Bachelors
h) University post-Graduate
i) Others (specify)……

5. What is your religion?

a) Born-again Christian
b) Protestant
c) Catholic
d) Muslim
e) Jehovah's witness
f) Others (specify)……

6. How often do you attend religious services?

a) Daily
b) More than once a week

c) A few times a month

d) Less than once a month

e) Never

7. What is the primary language spoken in your home?

a) English

b) Luganda

c) Both

d) Others (specify)…….

8. What was the main language spoken in your parents' home during your childhood?

a) English

b) Luganda

c) Both

d) Others (specify)

9. What is your current citizenship?

a) Ugandan citizen by birth

b) Ugandan citizen by Nationality

c) Others (specify) …….

Appendix VI: Semi-Structured Interview Guide

1. Tell me about your;

a) pregnancy experience that you aborted,

b) Induced abortion experience

(Probe for: thoughts, feelings; then, now).

2. The last time you had an induced abortion;

a. At what moment did you decide to carry out an abortion? (influential people when making decisions)

a. Who did you consult about your abortion decisions or your feelings about it?

b. Why did you decide to terminate the pregnancy?

c. What were your feelings at the time you decided to induce the abortion

d. What were your thoughts and feelings about the baby you were about to terminate?

e. What were your thoughts about the

i. Father of the baby,

ii. Your parents and relatives,

iii. Your religion and society

3. If you are given a chance to describe what having an abortion means to you,

a. What would you say?

b. What thoughts run in your mind?

c. What were your feelings at the time of the abortion?

4. The fact that you aborted, how does your abortion affect your day to day life, if at all?

5. The fact that you stay in Rakai, what does it mean to you and having had an abortion?

6. The fact that you have ever had an abortion,

a. How has it impacted the way you see yourself as a woman?

b. And the way others see you in your society?

7. How would you describe your religious beliefs? (Probe for the religiosity level, views of God/Allah and the beliefs on traditional gender roles, values of motherhood, female sexuality, religious/spiritual beliefs re-abortion and motherhood: Probe for: degree of involvement in religious community, church services, other daily religious activities)

8. The fact that you aborted, looking back now on your decision to have an abortion,

a. What was the hardest part for you?

b. Is there any ways you think your life has changed negatively as a result of this decision you made?

c. Any physical experiences encountered (like infection, bleeding, loss of weight, stress?

9. Besides, how has your life changed positively as a result of this decision?

10. According to your thinking, how do you expect you would have been supported in your abortion by friends, family, religious community, healthy professionals, and or mental health professional?

11. Now that you have told me all this, what are your reflections on today's experience and the opportunity to talk openly about your induced abortion

Appendix VII: Demographic Questionnaire Luganda

1 Wazaalibwa di?……../……/…….. olunaku lw'omwezi/omwezi/omwaka

2 Olinaemyakaemeka? ……..

3 Embeerayo mu byomukwaanoerietya?

a) Oli mu nsongazamukwano?

b) OliMufumbo?

c) Tolimufumbonayeoberan'omwagalwaawo mu byomukwano?

d) Tolimufumbonayeolinaomwagalwaawo mu byomukwanonga ate tobeeranaye?

e) Mwayawukana?

f) Owomukwano mulamu oba yafa?

g) ekirala(kirambulure)……

4 Wasoma kyenkanaki?

a) Tewasomako?

b) Primary

c) Siniya O level

d) Siniya A level

e) certificate

f) diploma

g) University Bachelors- digiri

h) University post-Graduate

i) Ekirala (kirambulure)……

5 Oliwadiini ki?

a) mulokore

b) mupolesitanti

c) mukatuliki

d) Musilaamu

e) MuJehovah

f) ekirala(kirambulure)……

6 emirundi emeka gyogenda musinzizo?

a) Bulilunaku?

b) Okusukamulundigumu e sabiiti?

c) Balirirwemumwezi?

d) No butaweza mulundi mu mwezi?

e) Togenderayo ddala?

7 Lulimi ki olukulu olwogerwa ewaka?

a) luzungu

b) Luganda

c) Zombi

d) ekirala(kirambulure)…….

8 Lulimikiolukulu olwayogerwanga mu makagaabazadde bo nga okyaali muto?

a) Luzungu

b) Luganda

c) Zombi

d) ekirala(kirambulure)…….

9 Oliwagwangaki?

a) Muna Uganda lwabuzaale

b) Muna Uganda lwabutuuze

c) ekirala(kirambulure) …….

Appendix VIII: Semi-Strucutred Interview Guide (Luganda Version)

1. Mbulirakubyewayitamuokuviiraddalangawakafunaolubutookutusizaddalakukikolwakyokulujamu? (Probe for: thoughts, feelings; then, now).
2. Anigweweebuuzaakokukusalawookwonengerijewaliowuliramukubyokujamuolubuto? (Probe for: feelings, thoughts; then, now; influential people when making decisions and since then)
3. Singaobadeoweredwaakakisaokunyonyolaokujamuolubutokyekitegeezajooli, kikyewandyogede? (Probe for: thoughts, and feelings).
4. Okujjamuukwo olubuto, buzibu ki bwekitadde ku bulamu bwo?
5. Okubeerakwo mu Rakai kitegeezakijooli?
6. Okujjamuukwo olubuto buzibu ki bw'olaba bwekikutadeko nga omukazi, n'abantu abalala jebakulabamu?
7. Enzikiriza yo oyinza kujinyonyora otya? (Probe for the religiosity level, views of God/Allah and the Virgin Mary, beliefs on traditional gender roles, values of motherhood, female sexuality, religious/spiritual beliefs re-abortion and motherhood: Probe for: degree of involvement in religious community, church services, other daily religious activities)
8. Okujjamuu kwo olubuto, w'otunula ku kusalawoo kwo, kiki ekyaasinga okukalubirira? Waliwo engeri embi zonna zolowooza nga zikyuusiza obulamubwo nga zeekuusa nakukusalawoo kwo kwewakola?
9. Newankubade, ofunye bulunjikki kukusalawo kwewakola?
10. Okusinzira ku ndowoozayo, osubira wandiyambidwa otya mikwaanojo, famile, abasawo oba n'abantu benzikirizayo?

Kati okusinzira nga bwogambyeebyobyona, olabaki ekiyinza okuva mukukwogerako kubyokujamu olubuto?

Appendix IX: A Letter of Invitation

Lived experiences of women who underwent induced abortion: a case study of Rakai district.

Principal investigator: Nalubega Margaret Joy

Introduction

You are invited to participate in the study about the women's experience that had an induced abortion. The purpose of this research study is aiming at getting a better understanding about the life experiences of women who have had an abortion.

The name of the researcher is Nalubega Margaret Joy. She is a postgraduate candidate in Public Health-Population/Reproductive Health-Uganda Martyrs University, Nkozi. As a requirement of master's program. Literature shows that women experience distressful effects from the experience of abortion, however, information on the long-term effects of this experience on women and how women have tried to integrate the abortion into their lives is not clear. Thus your role is to describe what your life experience after abortion was like, the effects it has had on your life and the kind of meaning you attach to it at this present time.

There is no immediate or long-range risks that are foreseen from participating in the study, however, discussions of the experiences of abortion are distressful for some women. Relieving that time of your life may develop emotional stress in you and if that happens, you will be free to ask to stop and may be resuming at a later time. In case the stress that will develop in you requires professional help, support services will be recommended. Three days after the interview, you will be contacted by phone, just to find out if you're okay or you experience some feelings of sadness, upset or anxiety and you wish to have any further help.

Participation in this study is completely voluntary, and you are very free not to answer any specific question(s), stop the interview or even withdraw from the study at any time, because no offence will be rendered to you at any one time. Your name is not to appear at any of the documents that will be used in this study, however you will be assigned an anonymous code, this code will be the same on your audiotaped information and all interview transcripts. The written

transcripts and the audiotapes from the study will all be kept confidential and only accessed by the researcher team.

If you have got any questions now or later about the study, please feel free to contact the principal investigator, Nalubega Margaret Joy as mentioned in the beginning of this letter. If you get any questions about your rights as a participant in this research study you may contact: the office of research ethics committee, Uganda Martyrs University.

You are free to keep this letter for any future references.

Thank you very much for your interest.

Appendix X: Map Rakai

Rakai, Uganda

APPENDIX G: WORK PLAN

DATE ACTIVITY	MAY 2016	JUNE 2016	JULY 2016	JULY 2016	AUG 2016	AUG 2016
Proposal writing and handing in						
Pilot test						
Data collection						
Coding, Data entry and analysis						
writing draft report						
writing final report / Defense						

APPENDIX H: PROPOSED BUDGET

ITEM	Quantity	Unit Cost (ush)	Total cost
PREPARATION			
travel to sites	4 trips	50,000	200,000
Questionnaire/consent translation	2	40,000	40,000
Stationery	1 ream of papers	20,000	20,000
Photocopy of questionnaire for pre-testing	50	400	20,000
Communication	5 cards	10,000	50,000
Audiotape recorders	3	60,000	180,000
Laptop	1	1,500,000	1,500,000
Subtotal			**1,830,000**
FIELD WORK			
Stationery	1ream	20,000	20,000
Travel to site	6trips	20,000	120,000
Accommodation	1month	30,000	900,000
Photocopying of questionnaire/consents	200	400	80,000
Research assistant(per day)	3	10,000	900,000
Participants' refreshments fee	7	2000	42,000
Communication	5 cards	10,000	50,000
Subtotal			**1,812,000**
Analysis			
Data entrant/analyst fee	1	400,000	400,000
Subtotal			**400,000**
Repot writing			
Stationery	1ream	20,000	20,000
Photocopying draft/dissertation	6	10,000	60,000
Hard cover binding	4	30,000	120,000
Subtotal			**200,000**
TOTAL			**4,722,000**

Justification of the Budget

All prices are in Ugandan shillings

A two-way travel trip to Rakai is 12,000, and this will be a journey of four, the other journeys will be to the healthy facilities from our places of residence in Rakai town council.

Each questionnaire and consent paper will be translated for 15000/= and verification of the translation will be for 10,000 /=

Each questionnaire with a consent form included will have four pages thus 400/= for each to be photocopied

An equal number of questionnaire in both English and Luganda will be photocopied, because the number of people who could answer in either language couldn't be predicted easily, so an equal number will be photocopied i.e. 215 making it 430, and the same will apply to the pre-testing,

The accommodation will be at 30,000/= for a month

Three research assistants will help to collect data each will be given 10,000/= which will cater for both their lunch and transport allowances

The data entrant will also analyze the data where 430 questionnaires are estimated to be worked upon each at around 930/=.

All eligible participants will be given refreshment for every interview that they undergo.