AN ASSESMENT OF THE PREVELANCE OF ABORTION IN THE OBSTETRICS&GYNECOLOGY WARD, KAMPALA INTERNATIONAL UNIVERSITY TEACHING HOSPITAL FROM JUNE 2013 TO MAY 2014

BY

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A RESEARCH REPORT SUBMITTED AS A REQUIREMENT FOR PARTIAL FULFILMENT FOR THE AWARD OF THE DEGREE OF BACHELOR OF MEDICINE AND BACHELOR OF SURGERY (MBChB) OF KAMPALA INTERNATIONAL UNIVERSITY (KIU)

DECLARATION

I, BIRYA DAN CHARO, hereby declare that this report is my original work and has never been presented in whole or part to any University for the award of a degree.

Name: **BIRYA DAN CHARO**

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APPROVAL

I have read through the manuscript of this report and I am satisfied that it is fit for presentation for the award of a Bachelor of Medicine and Bachelor of Surgery Degree (MBChB).

Supervisor: DR. JOSEPHAT MANIGA

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Date: ……..

ACKNOWLEDGEMENT

My heartfelt gratitude to my supervisor Dr. Maniga who kindly offered his time and effort to guide me in this endeavor, thank you and may the good Lord bless you and remember you.

My thanks also to the KIU fraternity for allowing me to conduct this research in the Hospital. Special mention are the Deans office, faculty of Clinical Medicine and Dentistry for sanctioning this research , the Obstetrics and Gynecology Department who allowed me to peruse through their data and the records department who helped me a lot in gathering data.

DEDICATION

To my almighty, all loving God for being exactly that, my God. To my family, for all the tireless effort, encouragement and love you have always offered me through my studies and life in general. Thank you from the depths of my soul and God bless you all so much.

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CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND

About 40-60 million abortions are performed annually worldwide and of these an estimated 20 million are deemed unsafe abortions 95% of which occur in developing countries.

The World Health Organization (WHO) estimates that at least 80,000 women die annually as the result of unsafe abortions, accounting for almost 13% of the maternal deaths worldwide. This percentage goes up to 60% in some countries.

Each year an estimated 297,000 induced abortions are performed in Uganda and nearly 85000 women are treated for complications. Abortions occur at a rate of 54 per 1000 women aged 15-49 and account for 1 in 5 pregnancies. The abortion rate is higher than average in the Central region (62 per 1000 women).Its the country's most urban and economically developed region. It's also very high in the northern region (70 per 1000). The abortion rate of 54 per 1,000 women of reproductive age is very high in comparison with the estimated rate for Eastern Africa which is 31 per 1,000 women. The WHO estimates that in the year 2000, 880 maternal deaths occurred per 100,000 live births in Uganda.

1.2 PROBLEM STATEMENT

In Uganda, just like in many areas of the world, abortion is a major problem requiring urgent attention. Unsafe abortions cause a lot of misery for individuals, families, communities and the government in general, with many lives lost and women left with irreversible morbidities.

KIUTH is not exempted. Being a relatively new hospital, the burden imposed on it by cases of abortion cannot be ignored. As a University teaching Hospital it serves both students and surrounding population who need to be informed of the consequences of abortion and measures put in place to curtail the problem.

1.3 RESEARCH OBJECTIVES

1.3.1 Broad objective:

- To find out the profile of women treated for abortions in Kampala International University Teaching Hospital (KIUTH) at the Gynecology ward in the period between June 2013 and June 2014.

1.3.2: Specific objectives:

- To find out the prevalence of abortions at KIUTH
- To find out the socio-demographics and Obstetric characteristics of these patients
- To find out the recorded complications among the patients.

1.4 RESEARCH QUESTION

- What is the profile of patients admitted with abortion at Kampala International University Teaching Hospital?

1.5 JUSTIFICATION

According to the theory of natural law, reproduction is acknowledged to be an inherent component of the natural human condition (e.g., fertilization, differentiation and birth are all a part of the natural human life span), and, thus, abortion is counter to this design.

However, abortion can be seen as a furtherance of the human ability to reason. The aforementioned principle of double effect, in addition to proportionality, can also be used to justify abortion.

Deaths and illnesses from unsafe abortions are preventable. Yet there are no local figures compiled to assess the magnitude of the cases of abortions.

I therefore set out to formally gather and provide information that could be used to make policies concerning female reproductive health in KIUTH and elsewhere.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction/ Definition

The World Health Organization defines abortion as "the termination of pregnancy from whatever cause before the fetus is capable of extra uterine life".

Spontaneous abortion refers to those terminated pregnancies that occur without deliberate measures before 22 weeks of gestation.

Induced abortion refers to termination of pregnancy through a deliberate intervention intended to end the pregnancy.

Induced abortion can either be conducted in a safe or an unsafe medical setting according to legal and health policy guidelines, or it may occur outside the medical system.

Safe abortion is a procedure and technique performed by trained health-care providers with proper equipment, correct technique, and sanitary standards.

Unsafe abortion is a procedure performed either by persons lacking necessary skills or in an environment lacking minimal medical standards or both.[1] *(ALARM International)*

The Centers for Disease Control and Prevention (CDC) defines abortion as legal if it was performed by a licensed physician or an appropriately licensed advanced practice clinician acting under the supervision of a licensed physician; it's illegal if performed by any other person.

An abortion related death is defined as a death resulting from a direct complication of an abortion (legal or illegal), an indirect complication caused by a chain of events initiated by an abortion, or aggravation of a preexisting condition by the physiologic or psychologic effects of abortion. All deaths determined to be related causally to abortion have been classified as abortion-related regardless of the time between abortion and death.

2.2 Epidemiology

In Uganda:

One in five unmarried Ugandan women aged 15-24 are sexually experienced, and one in ten are currently sexually active. 2 out of 5 of those sexually active use a modern contraceptive method but the rest are at risk of unwanted pregnancy.

Almost 110,000 women received care for complications of induced or spontaneous abortions in Ugandan health facilities in 2003. The rate of complications of induced abortion was 15/1000 women of reproductive age. The rate was higher in Central and Northern regions (18/1000) and below average in Eastern and Western regions (12-13 per 1000).

A 2006 study revealed a total of 846,181 abortions in the United States. The abortion rate was 16.1 abortions per 1,000 women aged 15-44 years and the ratio was 236 abortions per 1000 live births.

Women aged 20-29 accounted for 56.8% of all abortions while women at <15 years and >40 years accounted for the lowest percentages of 0.5% and 3.2% respectively. Adolescents aged ≤19years accounted for 116,613 of all abortions- approximately 14%.

Majority of the abortions (62%) were obtained at ≤8 weeks gestation and the methods used were as follows: surgical methods- 87.6% including vacuum aspiration, sharp curettage and dilation and evacuation. Non surgical methods accounted for 10.6%. all other methods were uncommon.

According to ethnicity, white women (Hispanic and non Hispanic white women) accounted for 55.8%, Black women 36.4% and other racial groups 7.8%. 83.5% of all women obtaining abortions were married women.

37.4% of all abortions were done by women identifying themselves as Protestants, 31.3% by Catholic women, 1.3% by Jewish women and 23.7% by women with no religious affiliations. 18% of all abortions were performed by women identifying themselves as “Born again/Evangelicals”.

2.3 Reason considered for Abortion:

When it came to reasons why women had abortions;

- 1% occurred because of rape
- 6% because of potential health problems regarding either or child
- 93% for social reasons- child is unwanted or inconvenient.

Other findings on reasons why abortions were performed in the U.S were;

- 95% were done as a means of birth control
- 1% because of rape or incest
- 1% because of fetal abnormalities
- 3% due to the mothers health problems

2.4 Complications of Abortion

These include:

IMMEDIATE:

- Shock

  It was diagnosed through clinical assessment of vitals and a constellation of vague symptoms. They comprised of weak rapid pulse, low BP, low HCT, cold extremities, sweaty, anxious and confused or comatose.

  <u>Management;</u>

  Airway, breathing and circulation resuscitation, elevate feet, keep warm, hyperbaric oxygen, IV fluids, IV antibiotics to cover both gram negative and gram positive organisms.

- Severe per vaginal bleeding

  It was characterized by heavy bright red bleeding with clots.

  <u>Management;</u>

  Airway, breathing and circulation resuscitation, elevate feet, i did haematocrits and haemoglobin assesment, hyperbaric oxygen, IV fluids, IV antibiotics to cover both gram negative and gram positive organisms. Also blood cross matching can be done case of transfusion.

- Injuries;

It was mostly assessed through nausea, vomiting, shoulder pain, cramping, distended painful abdomen, decreased abdominal sounds, tense, hard and rebound abdominal tenderness with fever.

Management;

Airway, breathing and circulation resuscitation, elevate feet, do haematocrits and haemoglobin assesment, hyperbaric oxygen, IV fluids, IV antibiotics to cover both gram negative and gram positive organisms. Also blood crossmatching in case of transfusion.A urine output chart should be plotted and abdominal X-ray or laparatomy is essential.

- Sepsis;

  It constituted chills, fever, sweat, foul PV discharge, abdominal pain, prolonged bleeding and mostly in shock. Almost all patients had this complication.

  Management;

  Airway, breathing and circulation resuscitation, elevate feet, do haematocrits and haemoglobin assesment, hyperbaric oxygen, IV fluids, IV antibiotics to cover both gram negative and gram positive organisms. Also blood crossmatching in case of transfusion.A urine output chart should be plotted and abdominal X-ray or laparatomy is essential.

  Assess for DIC, CBC and evacuate if stable or refer.

LONG TERM

- Asherman syndrome

  Often the patients experienced secondary menstrual irregularities characterized by a decrease in flow and duration of bleeding (amenorrhea, hypomenorrhea or oligomenorrhea) and become infertile.It affected all age groups in my research setting and can attribute it to adhesions restricted to only the cervix or lower uterus may block menstruation.

  Management;

  Surgical removal of adhesions restores infertility, hysteroscopy is used for visual inspection of the uterine cavity. Mechanical barriers like Foley catheter, saline-filled Cook Medical Balloon Uterine Stent and gel barriers prevent adhesions.Antibiotics prophylaxis is necessary.

- Fistulas

  This was the most common complication in our western side of the country. It can be either rectal vaginal fistula or rectal cystic fistula. It mostly affected older women due to multiparity .Mostly the contents which can either be urine or feacal matter is passed in the different orifices.

  Management;

  Patients need thorough couples counselling and prompt surgery performed to rectify the problem. Antibiotics should be instituted.
- Infertility

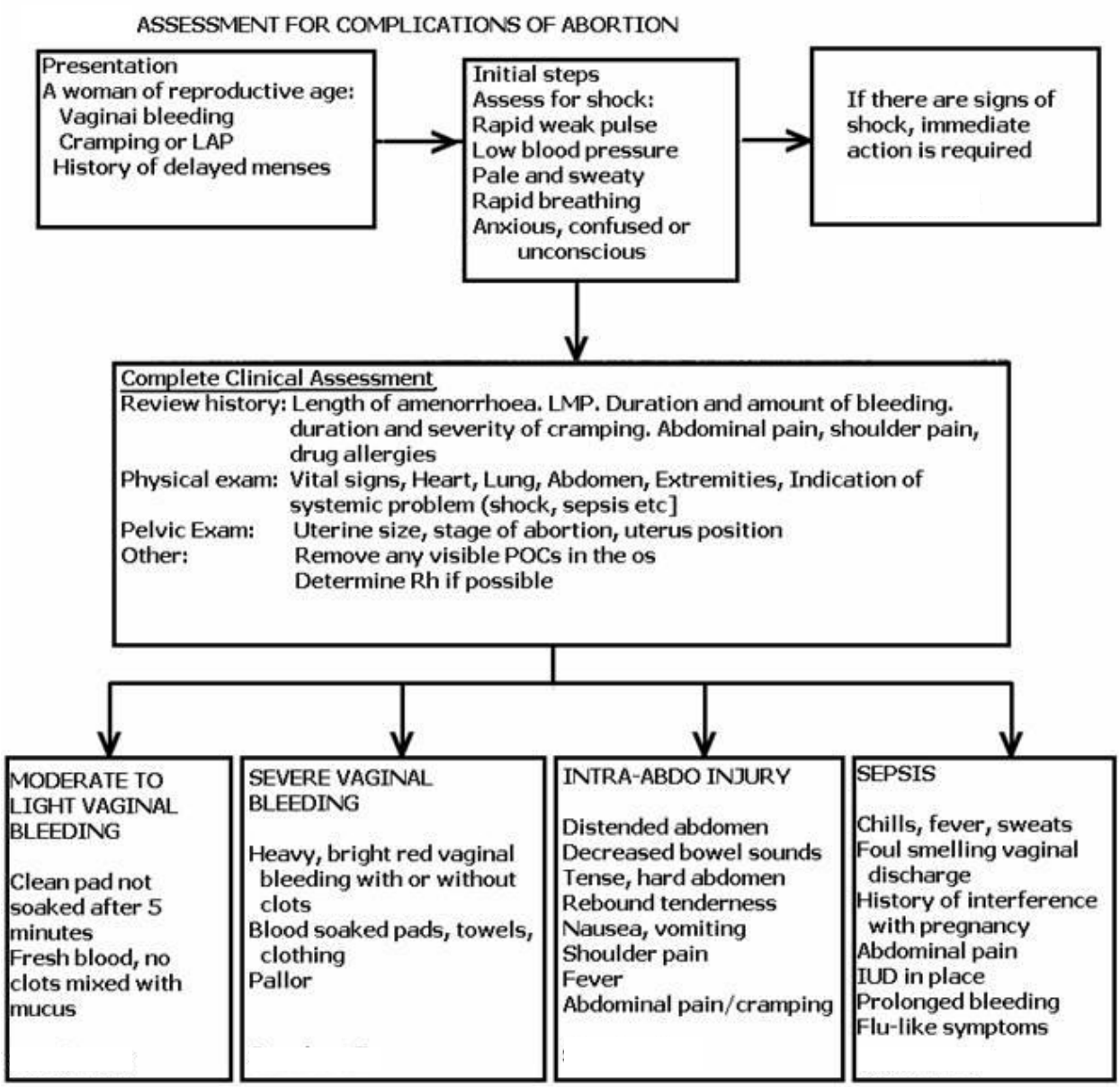
  It is the most dreaded complications of all, needless to say it occurs as a result of all the above complications. Of all cases I encountered, almost 0.6% of the mothers were going through this phase.

  Management;

  It needs couple therapy counseling for adopting options and other preferred choices.

Complications are most common among rural women, most of who go to unprofessional providers. Of women with abortion complications who receive care, about one third go to government and private hospitals, one half go to government and private health centers, and the remainder are treated by private midwives.

An estimated 65,000 Ugandan women each year ($1/5^{th}$ of all women who obtain abortions) experience complications but receive no treatment. Factors that explain why many Ugandan women with serious complications do not seek or receive treatment include the inability to pay for care, fear of revelations that they have had an abortion and concern that they will receive hostile or judgmental treatment from clinic or hospital staff.


ASSESSMENT FOR COMPLICATIONS OF ABORTION
Presentation
A woman of reproductive age:
Vaginal bleeding
Cramping or LAP
History of delayed menses
Initial steps
Assess for shock:
Rapid weak pulse
Low blood pressure
Pale and sweaty
Rapid breathing
Anxious, confused or unconscious
If there are signs of shock, immediate action is required
Complete Clinical Assessment
Review history: Length of amenorrhoea. LMP. Duration and amount of bleeding. duration and severity of cramping. Abdominal pain, shoulder pain, drug allergies
Physical exam: Vital signs, Heart, Lung, Abdomen, Extremities, Indication of systemic problem (shock, sepsis etc]
Pelvic Exam: Uterine size, stage of abortion, uterus position
Other: Remove any visible POCs in the os
Determine Rh if possible
MODERATE TO LIGHT VAGINAL BLEEDING
Clean pad not soaked after 5 minutes
Fresh blood, no clots mixed with mucus
SEVERE VAGINAL BLEEDING
Heavy, bright red vaginal bleeding with or without clots
Blood soaked pads, towels, clothing
Pallor
INTRA-ABDO INJURY
Distended abdomen
Decreased bowel sounds
Tense, hard abdomen
Rebound tenderness
Nausea, vomiting
Shoulder pain
Fever
Abdominal pain/cramping
SEPSIS
Chills, fever, sweats
Foul smelling vaginal discharge
History of interference with pregnancy
Abdominal pain
IUD in place
Prolonged bleeding
Flu-like symptoms

2.4 Abortion and the Law

Under Ugandan law induced abortion is only permitted when pregnancy endangers a woman's life. Legal abortions are very rare, given the restricted grounds, the demanding process for obtaining approval (3 doctors have to certify the need) and the likelihood that many providers and women are unaware of the specifics of the abortion law.

Still, many women obtain induced abortions in Uganda often from untrained personnel using unsafe methods. According to some studies, unsafe abortions are a leading cause of maternal morbidity and mortality in the country.

Morbidity due to unsafe abortion is very high in Uganda and each year, an estimated 85,000 women (15 of every 1,000 women aged 15–49) are treated for complications from induced abortion. Unless this trend changes the average woman will have a 50% chance of needing care for complications following an induced abortion in her lifetime. Treatment of abortion complications consumes scarce medical and health resources- Women who have abortion complications may require several days of hospitalization, treatment with expensive antibiotics, or oxytocin injections or blood transfusions and this in a country where shortages of drugs and blood supply are a major problem. Some women will suffer from long-term consequences, such as infertility.

Only 6 in 10 Ugandan women experiencing complications from abortion receive treatment within the country's formal health care system. Each year about 15 out of 1000 women of childbearing age are treated in medical facilities for abortion related complications. The proportion of physician performed abortions leading to serious health consequences is many times higher than in western countries, suggesting that some Ugandan doctors have not been properly trained in the use of D&C or are working under unsafe conditions.

CHAPTER THREE

METHODOLOGY

3.1 Study Design

A retrospective cross sectional study for the prevalence of abortion and profiles of women admitted with cases of abortion in the Obstetrics & Gynecology ward, Kampala International University Teaching Hospital

3.2 Study Setting

Kampala International University Teaching and Referral Hospital (K.I.U.T.H) is part of the Western Campus of Kampala International University, located in the Western region of Uganda, Ishaka town, Bushenyi district. The district has a population of 920,000 but the hospital itself serves a population of about 200,000 people.

The hospital is the second biggest in Uganda in terms of potential bed capacity, second only to Mulago National Referral hospital. It serves as a teaching Hospital for medical, nursing and pharmacy students among others and it is also a referral Hospital.

3.3 Study population

The study was carried out on the female patients admitted with a diagnosis of abortion in the Obstetrics and Gynecology ward in the specified time period.

3.4 Sampling procedure

It was done according to R. V Kvejcie & D. W Morgan table to determine sample size for research activities' education and psychological measurements with a population size of 800, to have a sample size of 484 people.

3.5 Inclusion criteria

- Patient admitted in the obstetrics& gynecology clinic with a diagnosis of abortion
- Admitted in the specified time period

3.6 Exclusion criteria

- Patients admitted with abortion but outside the specified time period

3.7 Data collection

Data was collected from the determined sample size using a data extraction forms.

3.8 Data analysis and Presentation

The data obtained was analyzed using Statistical Packaging for Social Scientists (SPSS). The results were presented in form of charts, tables and graphs.

3.9 Ethical consideration

Abortion is a taboo subject in many African societies and Religion therefore Uganda is no different. It also has a lot of emotional and psychological consequences on the woman. Therefore maximal care was taken to ensure patient confidentiality.

Patients' names were not included in the study.

To ensure anonymity, no names were used but instead codes only known to the researcher

CHAPTER FOUR

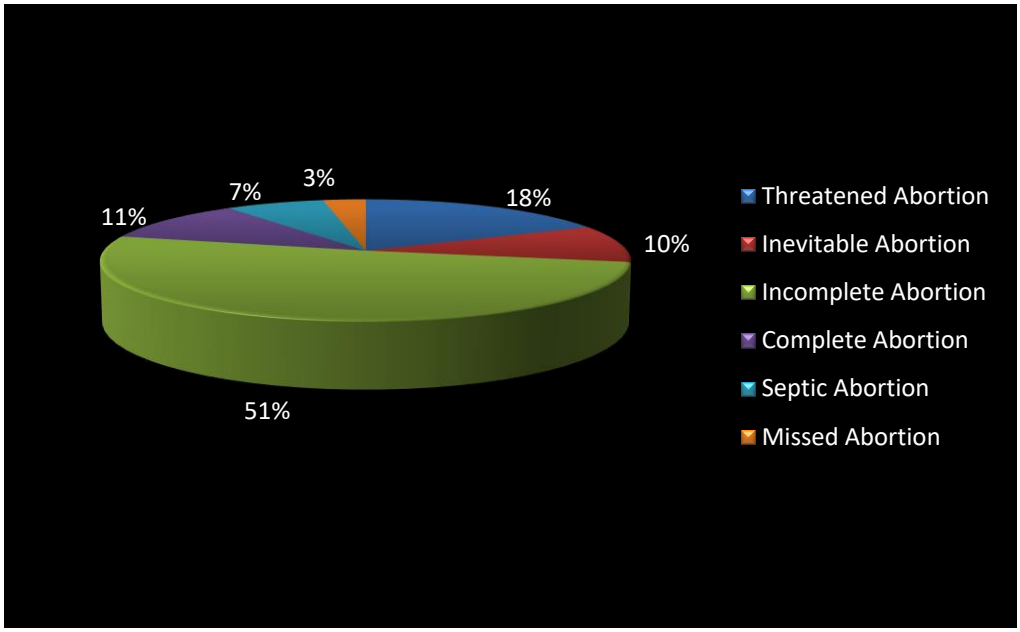
4.0 Data Presentation and Analysis

Table 1. Prevalence of cases of Abortion in the year June2013- May2014 at KIUTH

Month	Total Number of Patients	Number of patients with Abortion	Percentage
June	25	7	28%
July	47	8	17%
August	41	7	17%
September	33	5	15%
October	37	9	24%
November	24	8	33%
December	49	16	33%
January	39	5	13%
February	44	13	30%
March	56	16	29%
April	31	5	16%
May	58	13	22%
Total	**484**	**112**	**23%**

The prevalence of abortion cases did not have a corresponding pattern but an increased percentage towards the second half of year long research can be attributed to the increased number of pregnancy cases in much younger female patients.

Fig. 2 Types of Abortions diagnosed



The high percentage in incomplete abortions is due to patients self medicating themselves to flush the pregnancies and relying on incompetent medical practitioners to do the procedures. This is due to young age conceiving and it also accounts for the threatened abortion percentage too. The inevitable abortions are due to a young age in getting pregnant and an increased number in older women getting pregnant too.

Table 3. Recorded ages of the Patients admitted with Abortion

Age(Years)	Number of Patients	Percentage of Total no. of patients with Abortion
15-19	19	17%
20-24	25	22%
25-29	35	31%
30-34	14	12.5%
35-39	13	12%

40-44	4	3.5%
45-49	2	2%
Total	**112**	**100%**

Peak percentages of abortions in the age brackets of 20-24 and 25-29 are due to missed time pregnancy or lack of family planning, work demands and primigravida effects. The age bracket from 35-49 can be attributed to previous delivery complications and pelvis muscles incompetence.

Table 4. Recorded Parity of Patients admitted with Abortion

	Primigravida	**Multipara (2-5)**	**Grandmultipara (>5)**	**Parity not recorded in file**
Parity	18	53	20	21
Percentage	16%	47%	18%	19%

Fig 5. Number of Patients with recorded previous Abortions

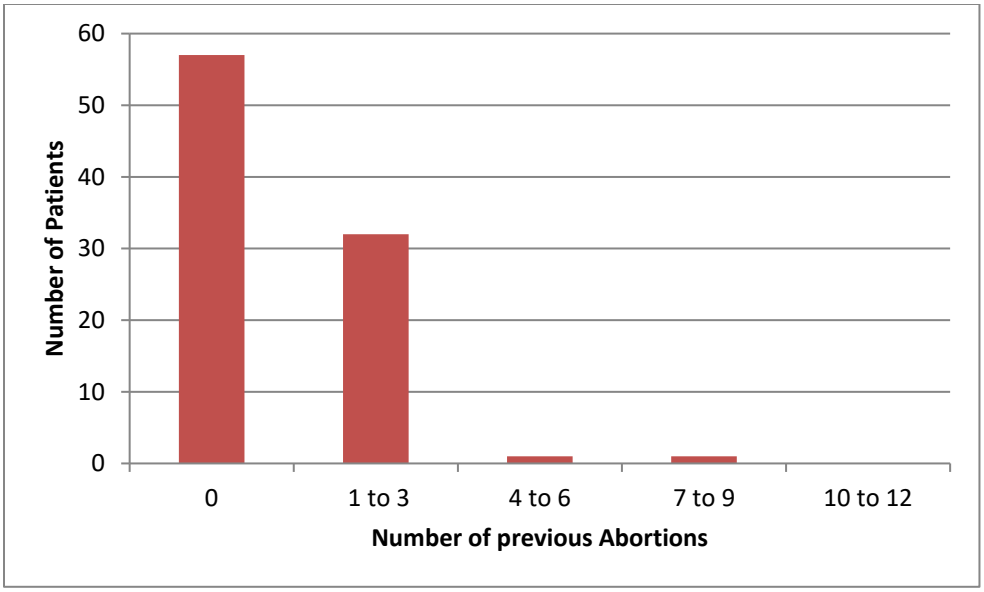
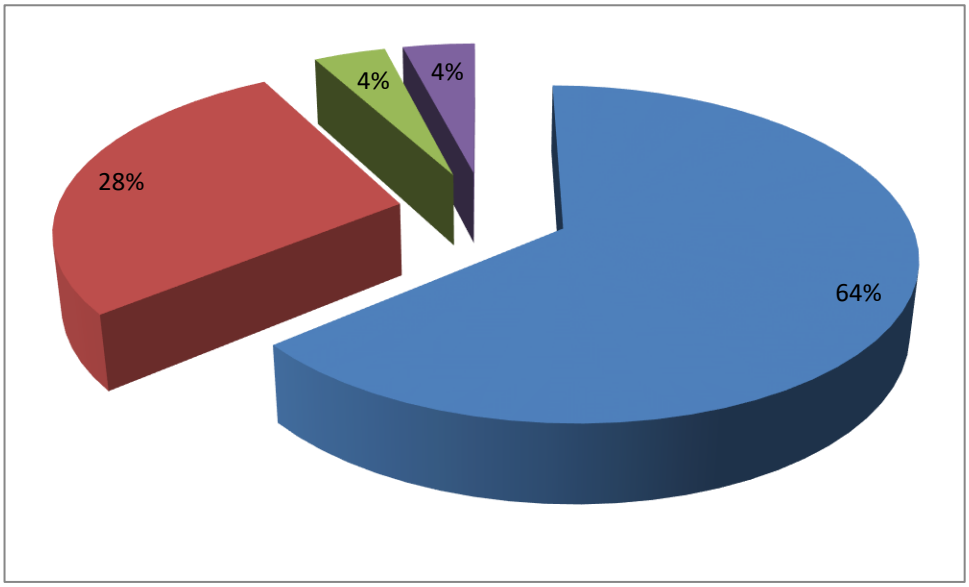


Fig. 6 Recorded complications among patients admitted with Abortion



KEY:

64%- Sepsis

28%- Anemia

4%- Fetal Demise

4%- Death

The major complication is sepsis and it can be linked to incomplete abortions, septic abortions and even missed abortions which they too carry a large number of prevalence in the stated research population. Anemia is due to intra and post procedural events while mostly fetal demise is inevitable. Death as a complication is a multifactoral event.

Table 5. Recorded Home Districts of Patients Admitted with Abortion

District	Number of Patients	Percentage
Bushenyi	72	64%
Kasese	1	1%
Kabale	1	1%
Kamwenje	1	1%
Mitooma	11	10%
Rubirizi	8	7%
Sheema	3	3%
Unrecorded Addresses	15	13%
Total	**112**	**100%**

The largest number of cases were recorded in Bushenyi. Although other districts were represented, not all of them co-operated but all in all Bushenyi district had the highest number and it is most likely due to the early age pregnancies.

CHAPTER FIVE

5.1 DISCUSSION

There were 122 recorded cases of abortion diagnosed in KIUTH in the year 2014. This contributed to a total of 23% of the total number of patients admitted in the gynecology ward in the same year. This rate is very high compared to the overall rate of 54/1000 women (5.4%) realized among the 15-49 years age group in the general population in Uganda. *(Singh S. et al 2006)*. One of the reasons could be that the hospital is a referral center receiving cases from nearby private Clinics, health centers and hospitals many of whom have attempted in vain to procure an abortion.

On the month by month breakdown, a relatively equal distribution was realized but the months of November and December had the highest number of patients admitted with abortion. Both had 33% of total admissions being diagnosed with abortion. The month of January had the lowest number with 13%.

In terms of actual patient numbers, January, April and September had the lowest number of abortion cases with only 5 patients each being admitted with abortion. March and December had the highest with a total of 16 patients each.

Three peaks in admissions of abortion cases were noted. First peak was in the months of February and March, the second in May and June and the third which was the highest peak in the months of October to December.

In terms of the types of abortion diagnosed, cases of incomplete abortion were by far the highest in number, totaling 51% of all the cases of abortion diagnosed. Threatened abortion followed far behind with 18% and the least in terms of percentage were cases of missed abortion, making up only 3% of the total.

Patients admitted with a diagnosis of abortion who were between the ages of 20-25 years accounted for 31% of the total, this was the largest group. 53% comprised the age group of 20-29 years- This was slightly lower than the 56.8% found by *Karen Pazol et al,2006* for the same age group in the general population.

The same study revealed that less than 19 year olds accounted for 14%. In my study, the same group of 15- 19 years accounted for 17% of the total.

The slight difference in percentage could be explained by sociocultural issues seeing that the studies were conducted in different countries. Also, the setting for this study was in a hospital while the other was for the general population in the USA.

Of the total number of patients admitted with abortion, 70% were 30 years old and younger and six patients admitted were over 40 years old, accounting for 5.5% of the total. The oldest patient admitted with an abortion was 47 years old. She was a Gravida 9, Para 8+0 and presented with a complete abortion.

A total of 16% of all the patients admitted with abortion were primigravidas. Multigravidas-in their 2^{nd} to 5^{th} pregnancy- accounted for the biggest group with 47% of all patients admitted with abortion. 18% were grandmultiparas while 19% did not have their parity recorded, unfortunately a frequent finding during the study.

Nearly 51% of the patients had never had an abortion prior to admission while 28% had 1 to 3 previous abortions. 2% had between 4 and 9 previous abortions. Again almost 20% of the patients did not have recorded data on previous abortions.

Post abortal complications were recorded in 22% of the patients. This was a very high rate compared to the Country total of 15/1000 women of reproductive age, representing 1.5%.

Of the recorded complications, post abortal sepsis was the most frequent with 64% of the total. Anemia following severe hemorrhage was second with 28%. One patient with threatened abortion had an IUFD and another patient died due to severe septicemia and peritonitis as a result of Uterine perforation during an attempted abortion.

KIUTH is located in Bushenyi District, in the Western Province of Uganda. An overwhelming 64% of the patients in this study came from Bushenyi District, the catchment area of KIUTH. 10% were from Mitooma District and 8% from Rubirizi District. All the other 4 recorded Districts had an average of about 1%.

5.2 Conclusions

- A quarter of all the patients admitted in the gynecology ward in the year 2010 had abortions
- Over half of the patients admitted with abortion had incomplete abortion, meaning many had tried to procure an abortion unsuccessfully and only came or were referred to KIUTH once this failed.
- Almost half of these patients were between 15 and 25 years old, young women in their prime of life. A fifth were still teenagers.
- Over 10% of all patients presenting with an abortion were having their first pregnancy. This could indicate that these pregnancies may have not been planned or wanted.
- Half of the patients had never procured an abortion before, indicating that if preventive measures were in place most of these abortions could possibly have been prevented.
- Only a fifth of the patients admitted with abortion developed complications. This could indicate good post abortal care services offered in the Hospital, among other probabilities.
- An element of recognition and confidence in the Hospital could also be seen in the fact that over 60% of the patients came from Bushenyi District, where the Hospitals catchment area is.

5.3 Recommendations

To the Obstetrics and Gynecology department

- A reproductive health program specifically on abortion- prevention, complications and post abortal services offered in KIUTH, should be instituted by the Department.
- This program should target all women in their reproductive age but even more the 15 – 29 year olds age group which was the most affected.
- This program should also be on an outreach basis targeting women who do not come to hospital for checkups.
- The Obstetrics and Gynecology ward should have an adolescent friendly environment seeing that so many of these patients were still in adolescence. This may include a part of the ward being set apart for adolescents and staff specifically trained to handle this young age group.
- Finally, the Obstetrics and Gynecology department should be encouraged to put more effort in record keeping. Many of the files missed some very crucial information, from patient's addresses to Inpatient numbers and even any complications arising from the patient's condition. Such information could be crucial when called upon for medico-legal purposes and even research undertakings.

To KIUTH Management

- The Hospital, while taking pride in the confidence expressed in it through the high attendance from the catchment area, should also work on encouraging even more women to attend its clinics. This can be done through vigorous outreach programs, staffing the obstetrics and gynecology outpatient with specially trained, welcoming staff and ensuring waiting time is minimal for patients attending the clinics.

All this is so as to avoid the burden of bearing the consequences of criminally induced abortions on the patient, the Hospital and the Community in general.

To the Ministry of Health

- More should be done to reduce this high rate of abortion:

  I. Newer policies on adolescent and female reproductive health based on recent studies.

  II. Allocation of funds to groups dealing with abortion.

  III. Motivating health workers to train on reproductive health through offering trainings and workshops among other incentives.

  IV. Coming up with new campaign programs on prevention of abortion and its complications, to be undertaken countrywide.

To the Government of Uganda

- Allocate more funds to the Ministry of health for reproductive health programs
- Seek help from Private individuals, Companies and Donors so as to build up the capacity of the Health Ministry programs.
- Make policies that take women and adolescent health into consideration.

APPENDIX ONE

SCHEDULE/TIME FRAME

PHASE	RESEARCH ACTIVITIES	TIME PERIOD
1.	Writing of the research proposal	**3 weeks**
2.	Data collection	**1 month**
3.	Data processing and editing	**2 weeks**
4.	Consultation with research supervisor	**1 week**
5.	Final data analysis	**1 week**
6.	Drafting of the final report and presentation	**2 weeks**
Total Duration		**3 months and 1 week**

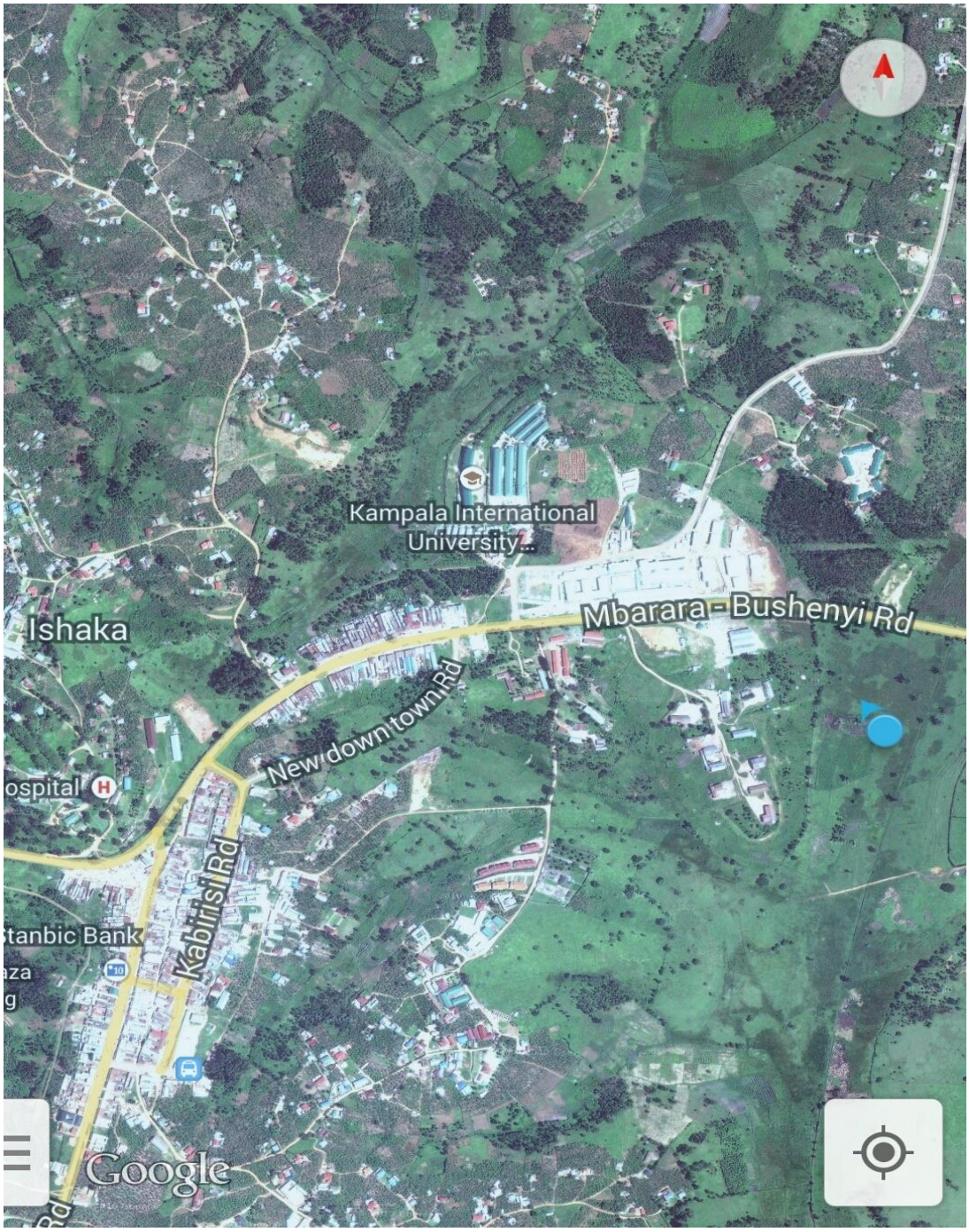
APPENDIX TWO

BUDGET

ITEMS	**COST (UGX)**
STATIONARIES	10,000
TYPING AND PRINTING MATERIAL	30,000
BINDING SERVICES	10,000
PHOTOCOPYING SERVICES	10,000
INTERNET SERVICES	20,000
FARE	30,000
MISCELLANEOUS	30,000
TOTAL	**140,000**

APPENDIX THREE - MAP

A map of the demographic study area- Kampala International University Teaching Hospital.



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