ASSESSMENT OF THE HEALTH OUTCOMES ASSOCIATED WITH UNSAFE ABORTION AMONG TEENAGERS IN KAMULI MISSION HOSPITAL

SUBMITTED BY

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DECLARATION

I, the undersigned, do here by declare that this dissertation is my original work, accomplished through extensive reading and practical guidance throughout the study and it has not been presented to any examination before for the award of a degree of bachelor of medicine and bachelor of surgery.

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APPROVAL

This research dissertation has been submitted for examination by the student under my supervision.

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DEDICATION

This research report is dedicated to my beloved wife Asekenye Lydia and my children namely, Hannah, Titus and my guardians Mr. Tigawalana Robert and Mrs. Nyanzi Cattie for their wonderful support towards my education.

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ABBREVIATIONS

ACHPR African Commission on Human and Peoples Rights

CARMMA Campaign for Accelerated reduction of Maternal Mortality in Africa

HIV Human Immune Virus

HR Human Rights

MDGs Millennium Development Goals

MOH Ministry of Health

NSFG National Survey of Family Growth

STDs Sexually Transmitted Diseases

SRHR Sexual Reproductive and Human Rights

UN United Nations

U.S United States

WHO World Health Organization

FIGO Federation of Gynecology and Obstetrics

MVA Manual Vacuum Aspiration

D&C Dilation and Curettage

UCBM Uganda Catholic Medical Bureau

DEFINITOIN OF KEY TERMS

Abortion	Is the removal of an embryo or fetus from the uterus in order to end pregnancy.
Abortion (induced)	Is the removal of an embryo or fetus from the uterus at a stage of pregnancy when it is deemed incapable of independent survival (i.e.at a time between conception and the 24th week of pregnancy)
Adolescence	The stage of development between childhood and adulthood,
Pregnancy	Is the period during which a woman carries a developing fetus, normally in the uterus
Sepsis	Is the putrefactive destruction of tissues by disease causing bacteria or their toxins.
Peritonitis	Is the inflammation of the peritoneum
Contraception	Is the prevention of unwanted pregnancy, which can be achieved by various means.
Unsafe abortion	Is a procedure for terminating a pregnancy performed by persons lacking the necessary skills or in an environment not in conformity with the minimal medical standards or both.
Mortality rate	The incidence of death in the population of in a given period
Morbidity	The state of being ill or having a disease.

Spontaneous abortion	Is the abortion that occurs without evidence of willful or inadvertent interference.
Threatened abortion	Is the type of abortion associated with trans-cervical bleeding with or without recognizable uterine contractions and pain but without cervical dilatation or expulsion of the conceptus.
Inevitable abortion	Is the type of abortion with bleeding uterine contractions and progressive cervical dilatation.
Incomplete abortion	Type of abortion where there is expulsion of only part of the retained products of conception.
Complete abortion	Is the type of abortion where all the products of conception have totally been expelled from the uterus.
Missed abortion	Is the type of abortion where there is retention of the fetus in the uterus for 8weeks or more after it has died.
Habitual abortion	Is a type of abortion where there is occurrence of three or more consecutive spontaneous abortion

ABSTRACT

Abortion remains a major global health issue, an approximately 44 million of the 210 million pregnancies that occur each year end in induced abortion, and almost half of them(4.9%) are estimated to be unsafe. Unsafe abortion is highly prevalent in countries with restrictive abortion laws, particularly in sub-Saharan Africa and Latin-America.

Comprehensive access to effective contraception and sex education are effective means of reducing induced abortion, and less restrictive completely eliminate the problem of unsafe abortion and its health consequences.

Carrying out this research was necessary in that it would help the public understand the significance of seeking medical attention from a high level facility other than waiting until they realize deterioration of their lives.

Majority of the cases were married (65.8%), with incomplete abortion (67.1%), unemployed (59.9%), HIV negative (61.0%), had carried more than one pregnancy (60.3%), dominant tribe was Basoga (71.6%), commonest complication was anemia (54.2%), unknown gestation age (26.2%), inadequate knowledge on contraceptives (56.8%).

Statistics also indicated that the post abortion patients suffered from many complications such as high fevers, shock, post abortion sepsis, perforated uterus, jaundice and death, but the most common complication was anemia (54.2%) that could have contributed to mortality and morbidity.

After Curettage, Induction or Manual Vacuum Aspiration, as well as other treatment modalities, patients' hopes for life were almost certain as majority of them were discharged in good conditions (85.6%), meaning that they improved.

The recommendation from the researcher was that the matters of abortion should be addressed at primary level to prevent unwanted pregnancies, at secondary level to avoid unsafe abortion by training mid level health providers as well as counselors, at tertiary level by preventing complications that follow unsafe abortion, and also at quaternary level to prevent the practice of consistent abortion.

CHAPTER ONE: INTRODUCTION

1.0 Background

This study is based on the conclusions reached at by all nations worldwide when they were adopting 'The Millennium Development Goals' (MDGs) in 2000. They set quantitative targets for ending poverty, improving health and promoting gender equality by the year 2015. MDG 5 was to "Improve Maternal Health", which now includes two complementary targets i.e. to reduce by three-quarters the maternal mortality ratio, and achieve universal access to reproductive health. Eliminating unsafe abortion is necessary to achieve MDG 5 targets and to ensure fewer maternal deaths, lower maternal morbidity and better reproductive health, especially for women and girls in developing countries.

The WHO defines unsafe abortion as a procedure for terminating a pregnancy performed by persons lacking the necessary skills or in an environment not in conformity with the minimal medical standards, or both. This definition was conceptualized within the frame work of emerging guidelines on the management of the complications of induced abortion and was intended to be interpreted within that context. Nothing in the definition pre-determines who should be considered a "safe" abortion provider or what the appropriate skills or standards for performing abortions should be. Such things are pretty static in that the procedure is done safely if it is done in a setting with sufficient resources in order to ensure outcomes are not significantly worse than elsewhere by someone else. Our criteria for assessing if facilities and training are adequate will change as evidence evolve, but the basic concept remains as outlined by WHO recommendations.

For example, WHO guidelines now recommend mifepristone and misoprostol- or misoprostal alone if mifepristone is not available- and vacuum aspiration in lieu of the sharp curettage used formerly. (K.Mahomed etal).

They now consider induced abortions provided at primary care level or by non physician health care providers as safe. In the definition, there is an explanatory note that "The persons, skills and

medical standards considered safe in the provision of abortion are different for medical and surgical abortion and also depend on the duration of the pregnancy. So what is considered safe is clearly interpreted. (WHO 2008)

Although unsafe abortions are, by definition risky, safety cannot be dichotomized because risk runs along a continuum. Risk is lowest if evidence-based method is used to terminate an early pregnancy in a health facility. It is highest if a dangerous method, such as the use of caustic substances orally or vaginally or the insertion of sticks into the uterus, is employed clandestinely to terminate an advanced pregnancy (Sedgh G et al., 2008)

Rates of induced abortion are difficult to measure because of underreporting or misclassification in surveys, hospital records and health statistics.

In light of this, WHO has historically used a pragmatic operational construct that measures safety in terms of only one dimension – legality- in developing its regional and global estimates of rates of unsafe -abortion. However, the informal use of misoprostol has added a layer of complexity to the concept of "safety" and as a result; it has become essential to apply a multi-dimensional risk continuum to measure abortion safety. Hence, the adverse outcomes associated with unsafe abortion need to be measured as well**.**

In developed countries, deaths resulting from unsafe abortion have reduced perhaps because of the safer methods as compared to the developing countries (Jewkes R and Rees H).

So the focus is now broadened from mortality to morbidity as well. Assessing the safety of induced abortion does not suffice, however.In the longer term, global consensus will be needed on the broader indicators used to assess the provision of safe abortion in line with WHO guidance- ie indicators capturing access, equity, quality of care and linkages to post-abortion contraception.

1.2 Statement of the problem

Abortion as a method of terminating pregnancy has greatly claimed the lives of women of childbearing age. The situation is actually worse among the teenagers who for many reasons consider it as the last resort of avoiding pregnancy growth after the other measures of

contraception have not been adhered to. The teenagers in this generation gap are students (primary, secondary, and tertiary/university who wish to continue with their education, married women who are happily married but have become pregnant accidentally or don't want another child at that time. Another group includes people of unstable marriages, miners, incest and rape, financially constrained and mothers infected with HIV/AIDs. (WHO, 1993)

However, abortion is not acceptable in many societies including our country Uganda where it attracts a penalty of Ten (10) years imprisonment if caught performing it together with cultural and religious beliefs and customs. This leaves the bearers of pregnancy to be victims of circumstance, and begin debating between life and death, hence ending up into the hands of poorly trained and unskilled health care providers or self induction of abortion using unsafe concoctions when no one is monitoring them.

The outcomes from such unsafe hands and procedures of abortion tend to differ among patients who undertake it such as excessive loss of blood, infections resulting into sepsis/peritonitis, perforation of the uterus, long stay in hospital and poor academic performance, poverty. (http://www.who.int/reproductivehealth/publications/unsafeabortion_2003/ua estimates03.pdf).

In some cases the outcome is even worsened and this could either be the problem of the health care provider, the patient herself or could be other factors the researcher believes to assess after the study. (WHO/MSM/92.5)

1.3 General objective

To examine the health outcomes of unsafe abortion among teenagers who undertook unsafe procedures in terminating the unwanted pregnancies and those who did not seek health care in high level facilities after spontaneous abortion

1.4 Specific objectives

a) To assess the severity of abortion complications and to determine the associated risk factors.
b) To assess the knowledge and awareness about the current contraceptive methods among the teenagers.

c) To examine the medical interventions for the patients who had undertaken unsafe procedures of abortion.

1.5 Significance of the study

The researcher believed that it would help in sensitizing the people about the importance of choosing other primary contraceptive options other than unsafe abortion. It would also be useful to the health care providers in that it would help them know the viable safe procedures of terminating unwanted pregnancies. It is also aimed creating awareness of the low-efficacy traditional family planning such as withdraw method, and the introduction of the modern methods like implants, hormonal contraceptives

1.6 Hypothesis

Most women who undertake unsafe procedures, and or handled by poorly skilled health care providers suffer from many complications associated with it.

1.7 Justification of the study

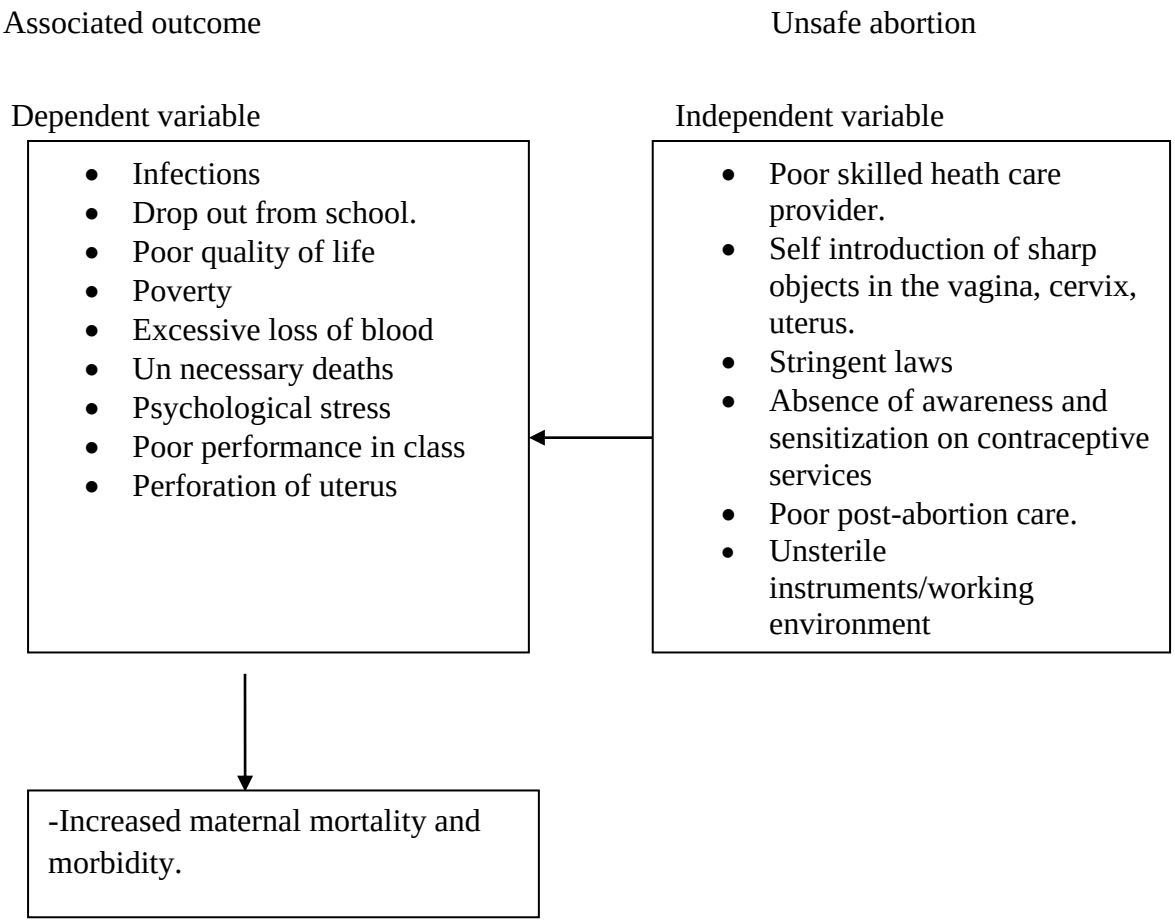
This was done as an undertaking to promote MDG 5 which is one of the elements stated in the Millennium Development Goals (MDGs) adopted by all governments Worldwide in 2000. This target hadn't been met here in the researcher's country and yet the primary interventions (contraceptive use) being used are less effective in addressing the consequences associated with unsafe abortion. Its prevention really required a primary, secondary and tertiary approach to address it.

The fact is that there exists enough evidence to show how women are losing their lives under the hands of unskilled personnel in attempting to terminate the unwanted pregnancies (Lubinga S.J.,etal). This is the opposite of those nations that are operating in line of meeting their targets of (MDG 5). World Health Organization deems unsafe abortion one of the easiest preventable causes of maternal mortality.

1.8 Scope of the study

The study focused at cases of admission in Kamuli Mission Hospital capturing the information from June/2010 to June 2014 in the maternity ward, outpatient department and theatre. This period was chosen because it would provide the most recent data and therefore allowed for the adequate number of cases captured.

1.9 Conceptual framework



Thus the adverse outcomes following unsafe abortion, that is to say, Infections, increased drop out from schools, poor quality of life, poverty, excessive loss of blood, unnecessary maternal deaths, psychological stress, poor academic performance in class, perforation of uterus etc are influenced by many factors such as;- Poor trained heath care providers, self introduction of sharp objects in the vagina, cervix and uterus, stringent laws, absence of awareness and sensitization on contraceptive services, poor post-abortion care, unsterile surgical instruments/working environment and others.

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

Women of all countries, of all ages, social standing, rich, poor, educated and uneducated married and unmarried, women with children all have abortions. So it is a very common and universal phenomenon, not restricted to promiscuous or irresponsible young women as is most generally believed. The first recorded evidence of an induced abortion was found in an Egyptian Papyrus from 1550 BC. (WHO 2011)

According to the Guttmacher Institute, complications from unsafe abortions in the developing world contribute to 47,000 preventable deaths each year. The advocacy organization points out that reducing the number of unsafe procedures worldwide is a public health imperative, since every woman should have the right safe reproductive choices for herself without risking her life. (WHO 2006**)**

In order to raise awareness about the essential need to have safer abortion, the institute released a video highlighting the disparity between access to reproductive right across the globe, as well as the commonalities between women who seek abortion. In all parts of the world, women have abortions for similar reasons, often for the similar reasons that women who have access to the modern contraception choose to use birth control. (MSM/92.5)

Women want to be able to delay having children if they are financially unable to care for a child or additional children, if they are not in a stable relationship with a partner who can help them care for a child, if they still need to finish their education. But contraception isn't readily available in many of the countries where women are dying from botched abortion procedure. (TPGHS 2003)

The institute further estimates that about 222 million women are trying to avoid pregnancy, and not using the modern contraception, which puts them at risk for unintended pregnancy and later opting for abortion. It also points out that the legality of abortion, unlike access to contraception has absolutely no correlation to the abortion rate, since women have abortion procedures regardless of the law. In fact some of the highest abortion rates are in Latin America and Africa, in places where abortion is highly restricted but where women have unintended pregnancies because they lack adequate access to contraceptive services. (WHO 2007A)

Actually some of the lowest abortion rates are in countries in Western Europe, where modern contraceptives are more readily available and where abortion is safe, legal, and accessible. Expanding access to contraceptives, rather than restricting abortion, will ultimately save women's lives. (MSM/92.5)

2.1 Why women seek for abortion

Women may seek for abortion because of many reasons i.e. personal reasons, health reasons, socioeconomic reasons, cultural/religious reasons, relationships, the desire to stop child bearing/space births, and no contraceptive services. (Jewkes R and Rees H,)

A woman may also want to have a child but the pregnancy may not be supported by her partner, family, or community, the pregnancy may threaten her healthy or survival, and the fetus may have an abnormality. So, where safe abortion is unavailable, women seek unsafe abortions using things like cassava plants, bleach, alligator pepper, chalk and alum, Bahaman grass quinine and other noxious substances. (Jewkes R and Rees H,)

2.2 Major causes of unsafe abortion in Africa

The major causes of unsafe abortion in Africa include, Low access to much needed Family Planning (Contraceptive Prevalence Rate < 20), high rates of unintended pregnancy leading to unsafe abortions contributing to deaths and disabilities, poverty and the high cost of safe abortion, lack of access to legal safe abortion services, gender inequalities-women have no say, stigma and silence around abortion, cultural and religious factors- personal beliefs, reluctance to do away with inherited antiquated laws dating back to 186, personal beliefs of people in position to implement services including providers. (Sedgh G et al.2008)

2.3 Worldwide incidence and trends

After declining substantially between 1995 and 2003, the worldwide abortion rate stalled between 2003 and 2008. Between 1995 and 2003, the overall abortion rate for the world dropped from 35 to 29. It remained virtually unchanged, at 28, in 2008. Nearly half of all abortions worldwide are unsafe, and nearly all unsafe abortions (98%) occur in developing countries. (Levels and trends, 2012)

In the developing world, 56% of all abortions are unsafe, compared with just 6% in the developed world. The proportion of abortions worldwide that take place in the developing world increased between 1995 and 2008 from 78% to 86%. Since 2003, the number of abortions fell by 600,000 in the developed world but increased by 2.8 million in the developing world. (http://www.who.int/reproductivehealth/publications/unsafeabortion 2003/ua estimates03.pdf.)

In 2008, six million abortions were performed in developed countries and 38 million in developing countries, a disparity that largely reflects population distribution. A woman's likelihood of having an abortion is slightly elevated if she lives in a developing region. In 2008, there were 29 abortions per 1,000 women aged 15-44 years in developing countries, compared with 24 in developed countries.

(http://www.who.int/reproductivehealth/publications/unsafeabortion 2003/ua estimates03.pdf.)

2.4 Regional incidence and trends

Both the lowest and the highest sub regional abortion rates are in Europe, where abortion is generally legal under broad grounds. In Western Europe, the rate is 12 per 1,000 women, while in the Eastern Europe it is 43. The discrepancy in rates between the two regions reflects relatively low contraceptive use in Eastern Europe, as well as a high degree of reliance on methods with relatively high user failure rates, such as the condom, withdrawal and the rhythm method. (WHO, 2008)

In Europe, 30% of pregnancies end in abortion, with a higher proportion in Eastern Europe than in the rest of the region. In this sub region, the abortion rate held steady at 43 per 1,000 women between 2003 and 2008, after a period of steep decline between the mid-90s and the early 2000s.

Western Europe, Southern Africa and Northern Europe have the lowest abortion rated in the world, at 12, 15, and 17, respectively. (WHO, 2011)

The abortion rate fell in Latin America from 37 to 31 abortions per 1,000 women between 1995 and 2003; it has held fairly steady since, reaching 32 in 2008. In Latin America, sub regional abortion rates range from 29 in Central America (includes Mexico) to 32 in South America and 39 in the Caribbean. The Caribbean (includes Cuba, where abortions are generally safe) has the lowest proportion of abortions in the region that are unsafe (46%), compared with nearly 100% in Central and South America. (Levels and trends, 2012)

In Asia, abortion rates across sub regions held steady between 2003 and 2008, ranging from 26 per 1,000 in South Central Asia and Western Asia to 36 per 1,000 in Southern Asia. Abortion incidence appears to have risen in china since 2003, after an extended period of decline. (Jewkes R and Rees H,)

Evidence shows that this is due to an increase in premarital sexual activity and disruptions in access to contraceptive services resulting from rapid urbanization. (SAMJ, 2005)

The overall abortion rate in Africa, where the vast majority of abortions are illegal and unsafe, showed no decline between 2003 and 2008, holding at 29 abortions per 1,000 women of childbearing age. Of course this includes the teenage group. (MSM/92.5)

And African women are dying because of inherited restrictive archaic colonial laws dating back to 1861 that have long outlived their usefulness and which the originators-- English, French, Portuguese, and Belgians colonialists from whom they inherited them have long since abandoned for good reason. The Southern Africa sub region, dominated by South Africa, where abortion was legalized in 1997, has the lowest abortion rate of all African sub regions, at 15 per 1,000 women in 2008. (MSM/92.5)

2.5 Maternal mortality and morbidity in Africa

Maternal mortality and morbidity remain a critical global problem in Africa. Only one country has met MDG 5 (Equatorial Guinea) and two are on track to meet by 2015 (Eritrea, Egypt).

In contrast, Botswana, Cameroon, Chad, the Congo, Lesotho, Somalia, South Africa, Swaziland and Zimbabwe saw maternal mortality rise since 1990. Vast majority are due to preventable causes like unsafe abortion that need minimal cost to address. (PASRHR, page 3-6)

In Africa the WHO estimates that up to 40 % of maternal deaths are caused by unsafe abortions (over a third!). So this is not an issue we can afford to ignore in our region and in our countries. East Africa (includes Uganda) has the highest rate, at 38, followed by middle Africa at 36, West Africa at 28 and North Africa at 18. (WHO, sixth edition).

2.6 Situation in Uganda

Every year in Uganda, about 1500 girls die from complications resulting from unsafe abortion. Abortion is hidden in the hemorrhage and sepsis figures but it is not captured .They hide it there because of stigma. This was said by Dr Charles Kiggundu, the president of the Association of Gynecologists and Obstetricians of Uganda, at a lawyers' meeting organized by the coalition to end maternal deaths through unsafe abortion held at Kabira country club in Kampala with an aim of exploring the use of a Human Rights approach to unpack the legal and policy frame work on abortion. (New vision October 22 2013)

Hemorrhage and sepsis are the leading causes of pregnancy-related deaths of women accounting for 26% and 22% of maternal deaths respectively. But 2008 ministry of Health statistics estimated that abortion-related causes account for 26% of maternal deaths in the country. (New vision October 22 2013)

Dr Collins Tusingwire, the Ministry Health Assistant Commissioner for Reproductive Health, stated that "We cannot look at only bleeding, infections, malaria, and HIV and expect to meet the Millennium Development Goals to reduce maternal deaths by 75% by 2015 when abortion accounts for a third of maternal deaths, implying that it can't be ignored if we are to achieve what we intended to do. (New vision October 22 2013)

Over 900,000 of Uganda's annual 2.2 million pregnancies are unintended and unplanned, and over 400,000 of this end up in abortion. A 2013 brief by the Guttmacher Institute states that Uganda's abortion rates are higher than the 18%World Health Organization's estimates for the

East African sub region and 13% of the world. (http://www.who.int/reproductivehealth/publications/unsafeabortion 2003/ua estimates03.pdf.)

To compound the situation further one in three married women are not using contraceptives even though they do not want to get pregnant. Despite abstinence campaigns, premarital sex is common in Uganda with one in three never-married women aged 15 to 25 years admitting to have already had sex. These adolescents and young women are particularly at risk of unintended pregnancy, because they are reluctant to seek contraceptive services and counseling since premarital sex is not socially acceptable. Sexual violence and coercive sex is also common. (Levels and trends, 2012)

The Guttmacher Institute brief quotes a study among the rural Ugandan secondary students that found that 43% of them had been very unwilling to have their first sexual experience. Such situations are building ground for unintended, unwanted pregnancies leading to unsafe abortion. Abortion in Uganda is only legal and permissible when a pregnancy endangers a woman's life or her physical and mental health. However, sections of the penal code make unlawful abortion criminal. This makes providers of service to fear.

(http://www.who.int/reproductivehealth/publications/unsafeabortion2003/ua estimates03.pdf.)

Dr Kigundu added that "nobody wants to be punished, so you do not touch, therefore there is need for the law to be interpreted to avoid giving a service and then end up in jail for 14 years. *(*New vision October 22 2013)

2.7 Abortion laws

a) The most restrictive- abortion permitted to save the woman's life or prohibited altogether,
b) Physical health grounds – abortion permitted to protect the woman's life and physical health,
c) Mental health grounds - abortion permitted to protect the woman's life, her physical health and also her mental health (definition varies, it can include psychological distress),
d) Socioeconomic grounds- permits consideration of factors such as the woman's financial situation, her age, marital status, number and well being of existing children,
e) Moral Medical grounds- apart from protecting the woman's life and health, it also allows abortion in cases of rape, incest or in case of fetal impairment,

f) Without restriction as to reason- it depends on the choice of the women (however in most laws there's a limitation based on the age of the pregnancy),
g) No abortion law (abortion considered to be a medical issue, e.g. Canada). (UNCESR 26 November 2010)

In Canada a Judge ruled that abortion is an issue to be discussed between a woman and her medical doctor. Implementing abortion laws can reduce recourse to unsafe abortion and hence reduce rates of maternal mortality and morbidity. (UNCESR 26 November 2010)

According to the World Health Organization, the first steps for avoiding maternal deaths are to ensure that women have access to family planning and safe abortion. This will reduce unwanted pregnancies and unsafe abortions. It is also a human rights obligation recognized by UN and African regional human rights standards. Yet, in many other African countries laws remain unimplemented resulting in preventable maternal death and disability. Several factors contribute to this failure. (UNCESR 26 November 2010)

In many countries, providers, policymakers, women, and other stakeholders, wrongly believe that abortion is completely criminalized and not available under any circumstance under the law. This may be due to lack of knowledge and information on the prevailing laws and absence of standards and protocols implementing abortion laws, as well as fear of criminal punishment. Thus, from country to country, a similar law can be interpreted very differently, and women's access to abortion services can be very different. (TPGHS, 2nd ed.2012)

For example in Uganda, Denis Kibirige, a senior state attorney on making a case for the enactment of a law to authorize abortion in the country said that the legal regime on abortion has not changed since the new constitution. He said," the Odoki Constitutional Commission noted that the majority of Ugandans were against abortion and recommended that it must be punished though societies practice abortion where a mother's life is endangered or in cases of rape and incest". (New vision October 22 2013)

Added that Article 22(2) of the constitution attempted to strike a balance between the two scenarios but noted that since 1995, no law had been enacted to give effect to Article 22(2) of the

constitution. The problem with abortion is not in the constitution. It is those charged with giving effect to Article 22(2). (New vision October 22 2013)

On a panel at the meeting, Justice Damalie Lwanga described the current arguments on abortion service as academic and not legal. “Law is very conservative subject. So attempting to go by the guidelines, your arguments may not be upheld that you did the right thing.” *(*New vision October 22 2013)

Speaking from a lawyer’s perspective Busingye Kabumba stressed that there was another side to the constitution’s Article 22(2) and that was the unborn child who cannot speak who depends on those able to speak. Both Women and the life of the unborn child were valued in the society and it was important to make the circumstances under which a pregnancy can be terminated clear so as not to make it difficult for the women to get what gives them dignity. But it was also important to clarify on whether it should be as easy as buying a condom or should be as complicated as getting a panel to which she explains she was raped? (New vision October 22 2013)

Charles Ngwena from the Centre for Human Rights noted that Uganda’s experience in addressing unsafe abortion was similar to other countries like South Africa or America. “There will never be consensus on such an issue,” adding that the public health dimension on abortion was not creating the urgency among policy makers even though the public health evidence of loss of life due to abortion was there. You need to strike a balance that will save 1,500 women who die from abortion related complications every year. (New vision October 22 2013)

Kigundu urged for sensitization of health providers on the law which he said a part from being unclear, its interpretation was being subjected to moral issues. “When a person is shot in robbery, we treat without thinking, but when it comes to abortion, the attitude changes,”

Ministry of health using the World Health Organization standards has guidelines for comprehensive Abortion Care which includes the prevention of unwanted pregnancy through Family planning, post abortion care. (New vision October 22 2013)

2.8 Constitutional threats – When does human life begin

There is a Clause "– life begins at conception—'' used by anti-choice and fundamentalists to deny women's rights. It is now in the Kenyan Constitution, and in Zambia draft. Attempts in Ghana failed. Tanzania and others resisted introduction of the clause. Only 15 countries (mostly Catholic) out of 200 worldwide recognize right to life before birth. Only 4 constitutions mention abortion – not constitutional issue. One country, Canada, has no abortion law at all. (TPGHS, 2nd ed. 2012)

2.9 African Regional RH Policy Framework

The Abuja Declaration mandated all African heads of state to show commitment and allocate 15% of their annual national budget to improve health services including RH services. *(*US agency for international development)

There is a Protocol on the rights of women in Africa which is a treaty that includes protections for women's reproductive rights, and the right to safe abortion. 36 countries ratified. (US agency for international development)

The Continental Policy Framework on SRHR was created by the African Union Commission for the promotion of Sexual Reproductive and Human Rights in Africa. (TPGHS, 2nd ed.2012)

There is also the Maputo Plan of Action that was adopted by African Ministers of Health in 2006 and approved by Heads of state in Jan 2007. (US agency for international development)

Campaign for Accelerated Reduction of Maternal Mortality in Africa serves as an advocacy platform for improvement of maternal and child health and it has been launched by 36 African Union member states. It recognizes that preventable maternal mortality are pressing human rights issues and calls for the implementation of specific legal obligations. Unsafe abortion is one of its indicators. (US agency for international development)

The Protocol to the AU Human Rights Charter on the rights of Women in Africa also known as the Maputo Protocol was adopted by the Heads of State and Governments in 2003. It is the only regional human rights treaty that explicitly provides the right to safe abortion. Ratification places an obligation on state parties to implement the protocol. Few nations have acted to fully apply this instrument, for the sake of women and families in our countries? (TPGHS, 2nd ed. 2012)

At the African Union Summit theme of Maternal and Child Health in 2010-Kampala, all the Heads of State requested annual reports and both the 2012 and 2013 detailed the problem of unsafe abortion and the need for review of restrictive laws and addressing stigma. (US agency for international development)

At the African Commission on Human and Peoples Rights (ACHPR) Banjul Gambia, head of states were accountable for implementing the African Charter on HR and the Maputo Protocol, Special Rapport on the Rights of Women in Africa was presented and Questions to governments on abortion were raised. Civil Society Organizations were there presenting alternative and shadow reports. Malawi was set to be the first country to report on Women's Protocol and abortion in Oct. 2014, considering General Comments on Art 14 2 of Women's Protocol on abortion and family planning. (US agency for international development)

The 1973 U.S. Supreme Court decision in *Roe v. Wade* resulted in marked change in maternal mortality and the rate from induced abortions was brought down from 39% in 1972 to 6% in 1974. Today, the overall risk of death from legal abortion is less than 1 per 100,000 procedures. About 1.3 million legal abortions are performed in the U.S. annually. Each year, 2-3% of all women of reproductive age have an abortion. (Ob and Gyn 3rd Edition page 106-108)

CHAPTER THREE: METHODOLOGY

3.0 Introduction

This chapter gives a brief description of the design, research area, sample selection, research instruments and pre-test, ethics in the data collection methods, study population, sample size, sampling procedure, and techniques.

3.1 Study design

The study was both qualitative and quantitative nature. It involved the use checklists designed by the researcher.

3.2 Study area

The study was carried out in Kamuli Mission hospital which is approximately 152km from Kampala and 66km from Jinja town. This facility is one of the biggest facilities constructed on a Catholic Church foundation in the eastern part of Uganda and centered at the heart of Kamuli District in Bugabula North as the catchment population, serving most of the surrounding districts of Buyende, Kaliro, Kayunga, Luuka and many others. The hospital records showed that the average outpatient department attendance is 42,009 patients per year, admission of 10,663 patients per year, deliveries are 2,078 per year, and average caesarian section rate of approximately 30.8%, a reflection of the hospital's relevance as a referral facility and enjoys an average annual bed occupancy rate of 63.3% 164.

3.3 Sampling procedure

The researcher was guided through the departments for data collection (Records, Outpatient department, and Maternity). Then simple random sampling method was used to assess the cases.

3.4 Sources of data

The data was collected from general admission books in maternity ward, outpatient department, and UCBM bulletin.

3.5 Study population

The population under consideration was mothers who had undertaken abortion intentionally (criminal abortion) or spontaneously but did not seek for medical treatment on time. These mothers were between 15-25 years, married and unmarried, employed and unemployed.

3.6 Sample size

This will be determined by use of Kish and Leslie formulae (1965)

$(n)=Z^2Pq/d^2$ for the population>10000

n-sample size

Z-normal distribution probability

p-proportion of target population under study

q=1-p

d-margin of error at working confidence interval

n-total population under study

but p=0.5(50%), and q, also=0.5(50%), Z=1.96, and d=0.05

$(1.96)^2$x (0.5x0.5)/0.05^2

348 but for this case the researcher reviewed as many patients' charts as possible and came up with 292 cases in the period between June 2010 and June 2014.

3.7 Data collection

Self modified checklists were used to review the information pertaining abortion from the records, outpatient and maternity departments.

3.8 Data processing and analysis

Information was processed and analyzed manually using calculators and presented in Tables and pie-charts using the excel program.

3.9 Checklist

This is a formalized set of questions the researcher and the research assistants used in capturing the necessary information, and served as a tool based on to answer the different problems under investigation.

3.1.0 Limitations of the study

Because unsafe abortion is often done clandestinely by untrained individuals or by pregnant women themselves, much of it could have gone undocumented and this might have affected the process of data collection by the researcher. Wrong diagnosis of mothers admitted with bleeding from other causes other than abortion might have also contributed to an under/over score in the data collected.

Short time allocation for the research, long distance from University to the study area, power disruptions, switching from one supervisor to the other acted as hindrance to the success of the study.

3.1.1 Ethical considerations

The researcher obtained an authoritative letter from the Faculty introducing him the facility where data was to be collected.

CHAPTER FOUR: DATA ANALYSIS AND PRESENTATION

Introduction

This chapter gives the results of the study that was done by analyzing, interpretation and presentation

The study was a retrospective one that concentrated on chart review of cases that had undertaken unsafe procedure of inducing abortion at different gestation ages using a check list.

A total of 292 cases between 15 and 25years of age admitted with diagnosis related to unsafe abortion were critically assessed for, knowledge on contraceptives, level of education, marital status, tribe, religion, occupation, parity, gestation age, mechanism of abortion, HIV status, investigations, diagnosis, medical intervention, complications, duration of stay in the hospital,

The above implied that the candidates under study included both prime and multi-gravid mothers who under unknown or intentional circumstances lost their pregnancies as will be shown in the tables/charts below.

Table 1 Age distribution in patients admitted to hospital with abortion

Age range	Frequency	Percentage (%)
≤15	17	5.8
16-17	55	18.8
18-19	74	25.3
20-21	80	27.4
22-23	48	16.4
24-25	18	6.2
Total	**292**	**100**

The table indicates that the largest proportion of cases admitted with abortion for the duration under study was in the age range of 20-21(27.3%) while as the least age group was≤5 (5.8%)

Table 2 **Marital status of the patients**

Marital status	Frequency	Percentage (%)
Married	192	65.8
Not married	100	34.4
Total	**292**	**100**

The table indicates that majority of the cases in records were married 192(65.8%) compared to 100(34%) who were not married.

Table 3 Occupation status of the patients

Occupation	Frequency	Percentage (%)
Student/pupil	57	19.5
Employed	60	20.5
Non employed	175	59.9
Total	**292**	**100**

As shown in the table above, majority of cases admitted with abortion were not employed, that is 175(59.9%) and the smallest group was that of the students and pupils 57(19.5%).

Table 4 Knowledge on contraceptives

Knowledge of contraceptives	Frequency	Percentage (%)
Yes	126	43.2
No	166	56.8

Total	**292**	**100**

The largest proportion of individuals as found in the patients' treatment charts did not have knowledge of the artificial contraceptive methods with166 (56.8%) and only 126(43.2%) had adequate information regarding contraceptives.

Table 5 Parity for the patients

Parity	Frequency	Percentage (%)
Prime gravid	116	39.3
>1	176	60.3
Total	**292**	**100**

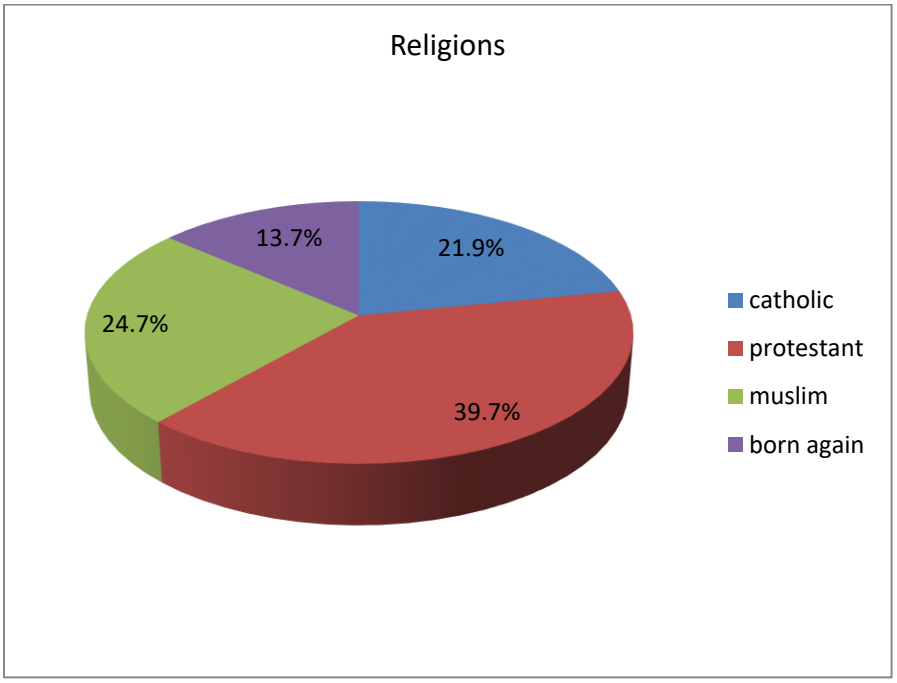
It was shown that the highest number of cases recorded were those whose parity was exceeding one, that is 176 (60.3%) as opposed to those who were carrying pregnancy for the first time (39.3%)

Table 6 Level of education for the students/pupils

Education level	Frequency	Percentage (%)
Primary	19	33.3
Secondary	29	50.9
Tertiary/university	9	15.8
Total	**57**	**100**

Among the individuals admitted in the hospital were students and pupils and in this category, the highest proportion was 29(50.9%) by secondary students, with the least being 9(15.8%) by university students

Figure 1 Different religion for patients



From the figure above, the patients admitted in the hospital were of different religious background but the biggest proportion (39.7%) belonged to the Protestant faith with the least proportion (13.7%) belonging to the Born again.

Table 7 Tribes of patients admitted with abortion

Tribe	Frequency	Percentage (%)
Soga	209	71.6
Teso	20	6.8
Gishu	11	3.8
Kenye	17	5.8
Ganda	14	4.8
Nyoro	21	7.2

Total	**292**	**100**

According to the table above, the biggest number of cases was Basoga by tribe that is 209(71.6%) and the least were Bagishu with 11(3.8%).

Table 8 Gestation age of patients admitted with abortion

Gestation age (weeks)	Frequency	Percentage (%)
<4	07	2.4
4-8	50	17.1
9-12	58	19.9
13-16	41	14.0
17-20	45	15.4
21-24	11	3.8
25-28	04	1.4
Not known	76	26.2
Total	**292**	**100**

As shown in the table, the findings revealed that majority of the patients admitted in the hospital symptoms threatening their pregnancy didn't know their gestation age 76(26.2%). But 58(19.9%) individuals who presented with features posing threat to their pregnancy were between 9-12 weeks of amenorrhea as opposed to 4(1.4%) who were between 25-28 of gestation and this was the least group.

Table 9 HIV status of the patients who are under study

Test	Frequency	Percentage (%)
Negative	178	61.0
Positive	19	6.5
Not known	95	32.5

Total	**292**	**100**

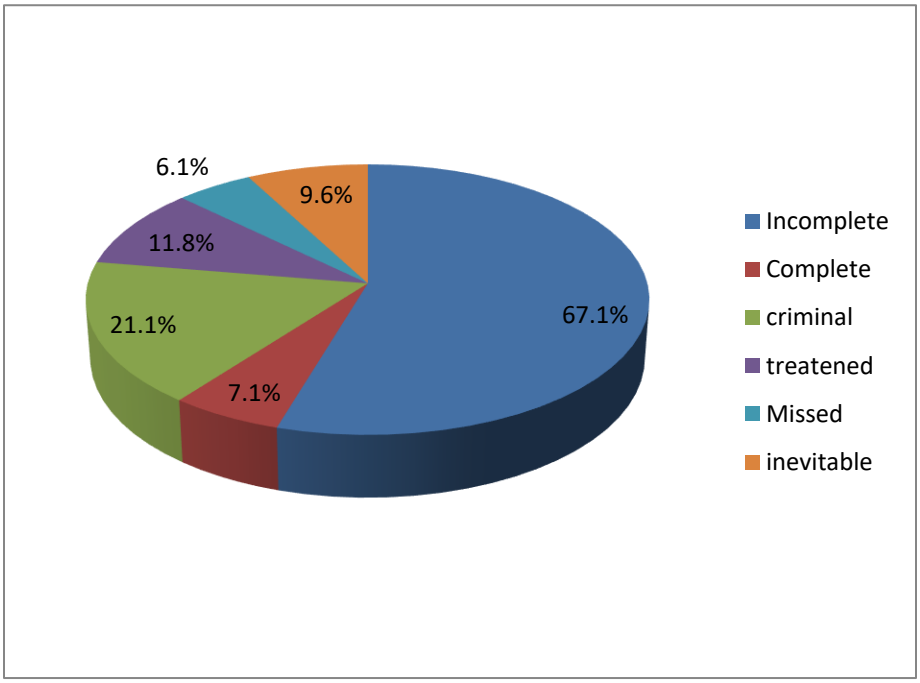
From the table above, majority of the individuals as looked up in the records were HIV negative with 178(61.0%) and a small proportion of positive individuals 19(6.5%).

Table 10 Investigations carried out on patients with abortion

Type of investigation	Frequency	Percentage (%)
Hemoglobin estimation	66	18.9
Pregnancy test	21	6.0
HIV test	21	6.0
Blood group	50	14.3
Blood slide/RDT	29	8.3
Ultra-sound	140	40.0
Others	23	6.6
Total	**350**	**100**

As seen in the table above, a variety of investigations were done on patients admitted in the hospital, but the leading investigation carried out was Ultra-sound with140 (40%) and the least ones done were the pregnancy and HIV tests with 21(6.6%) each respectively.

Figure 2 Different types of abortion



The leading type of abortion as found in the patients' files was incomplete abortion with 153(67.1%) and the least was septic abortion with 08(3.5%)

Table 11 Mechanism of abortion

Mechanism	Frequency	Percentage (%)
Criminal	72	24.7
Not known	220	75.3
Total	**292**	**100**

The table shows that most of the abortions that the patients suffered had no known cause as represented by 220 individuals (75.3%) yet 72 individuals as observed in the medical records

attempted to terminate their pregnancies (criminal abortion) and this accounted for24.7% of the total population under study.

Table 13 Medical intervention

Treatment modality	Frequency	Percentage (%)
Evacuation/(D&C)	181	61.4
Manual removal of RPOC	03	1.0
Blood transfusion	16	5.4
Bed rest	27	9.2
Induction using drugs	53	18.0
Explorative laparatomy	01	0.3
Other	14	4.7
Total	**295**	**100**

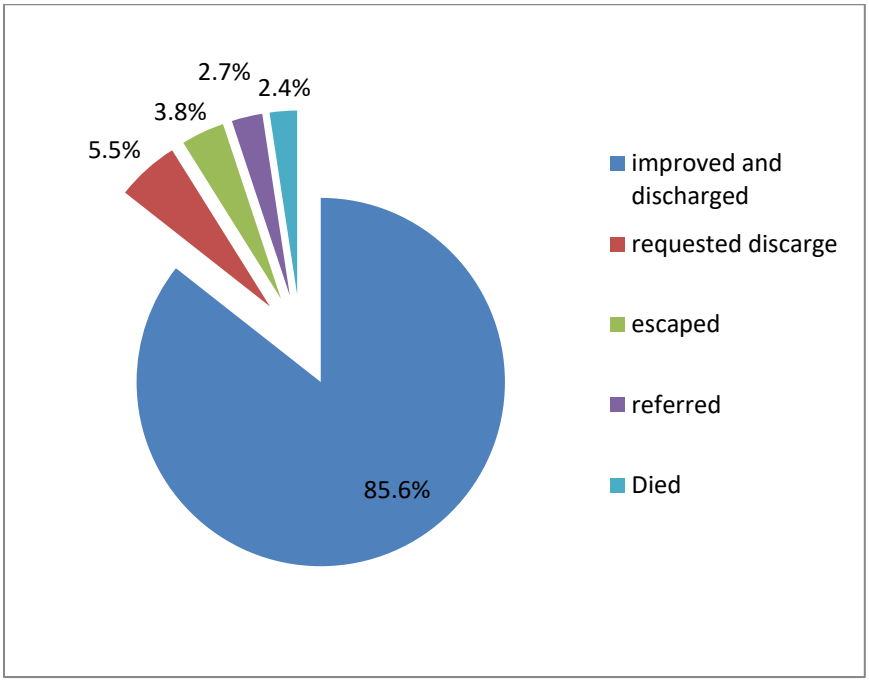
Out of the 295 procedures and choices of medical interventions, Evacuation/D&C with 181(61.4%) was the leading treatment option for most of the cases. And the least was explorative laparatomy with 01(0.3%)

Table 14 Complications of abortion

Complication	**Frequency**	**Percentage (%)**
Anemia	13	54.2
Post abortion sepsis	05	20.8
Perforated uterus	01	4.2
Peritonitis	03	12.5
Others	02	8.3
Total	**24**	**100**

Above in the table are the different complications recorded from the patients' files and treatment sheets before and after medical intervention. The highest percentage was shown by those individuals who developed anemia as 13 (54.2%), followed by those who developed post abortion sepsis. It was also noted that perforation of the uterus was a rare complication where by only one case (4.2%) was recorded in the total population under study. However, some individuals, developed peritonitis, 3(12.5%) as well as other complications 2(8.3%) which included Jaundice, bed sores, malnutrition due to longer stay on the wards.

Figure 3 Health outcomes of unsafe abortion



The above figure indicates that the highest proportion of individuals improved after seeking medical attention in the hospital as 250(85.6%). However, a small proportion of them lost their lives, as was indicated by 7(2.4%). Others requested for discharge back home 16(5.5%), some escaped 11(3.8%), while as others 8(2.7%) were referred to other health facilities for further management.

T**able 14 Duration of stay in hospital**

Time (days)	Frequency	Percentage (%)
1	83	22.5
2	107	32.8
3	46	14.1
4	45	13.8
5	16	4.9
6	08	2.5
7	08	2.5
>7	13	4.0
Total	**326**	**100**

The table highlights on the time spent in the hospital after the necessary medical attention had been extended to the patients. The majority of patients stayed in the hospital for an average number of two days 107(32.8%) and went back home when improved. On the other hand, some individuals stayed in the hospital for more days, say six, seven days and above.

CHAPTER FIVE: DISCUSSION, CONCLUSION AND RECOMMENDATION

DISCUSSION

This chapter highlights the main findings in this study. The study checked the adverse outcomes of unsafe abortion in teenagers who were admitted in the Kamuli Mission Hospital from June 2010 to June 2014.

The study was done because many mothers out there in the different communities make poor choices for their maternal care instead of seeking better health services from well equipped facilities with well trained personnel. So this material will provide information regarding the medical implications resulting from different mechanisms of abortion and the importance of seeking medical attention in improved health facilities available.

Though the study showed that majority of patients were admitted with different forms of abortion and life threatening complications, there after majority of were discharged when improved following medical treatment (Table 14)

The patients' age group was a range of 15-25 with the mean age being 20. The majority of cases were observed in the 20-21 age groups with 27.4% (table1). This age pattern slightly differs from the WHO report of 2004 (Reproductive Health Matter volume 20) which estimates that almost 26% of un safe abortions in Africa are in women age20-24 years and over 40% of unsafe abortions among adolescents in developing world occur in Africa. This was probably contributed by poor utilization of government facilities, low knowledge of the existing contraceptive methods, unstable families.

It was noted that cases of unsafe abortion were higher 192 (65.8%) among married women than in those who were not married. This could probably have depended on the individual characteristics say age, educational level, number of children, sex of the children. This was also supported by Cuntongo Wang 1790 to 2010. The less stringent the family planning policy, the

less likely married women were to undergo an induced abortion. Only a small proportion (34.2%) was composed of unmarried patients.

It was also revealed that most of the cases admitted in the hospital had no prior knowledge of the contraceptive methods as shown by 166(56.8%) and only 126(43.2%) were knowledgeable about the existing family planning options in the peripheral health facilities where they came from. This could be attributed to their level of education, lack of awareness of the existing birth control methods, negative attitude, cultural, religious and ethnic beliefs and customs. But post abortion counseling was given to them by the doctors and midwives as part of the post abortion care before discharge back home. The above seem to agree with Douwe A A Verkuyi in his study "Two world religions and family planning" when he cited that the bishops refuse to discuss the possibility of promoting the use of condoms for contraception or even for AIDS prevention purposes.

Furthermore, the study revealed that most of the mothers who admitted didn't have enough knowledge about their pregnancy status 76(26.2%) until they reached hospital where they were investigated and later given the right information. This could have resulted from lack of community awareness about maternal health services, less accessibility of the mothers to the care centers, poor infrastructures, less involvement of the men in maternal health issues, low levels of education. However, this was followed by 58(19.9%) of the cases within the range of 9-12 weeks, then 50(17.1%) at 4-8weeks, 45(15.4%) at17-20 weeks, 41(14.0%), 11(3.8%) at 21-24 weeks and 4(1.4%) who were in the range 25-28 weeks of gestation, implying that the risk of abortion reduces with late gestation age and increases with early gestation age.

The mechanism (cause) of abortion was hard to be established by the clinicians. For example knowing whether the cause of abortion was natural or intentional especially in mothers who had carried pregnancies previously was a big challenge. However, 220(75.3%) of the cases were considered to be natural as their cause could not easily be established as compared to 72(24.7%) that were recorded as criminal in nature because their causes and intentions for terminating the pregnancies were identified. Some of the objects used to induce abortion recorded from the patients' general admission charts showed that some individuals used pieces of plant stems, leaves, over dose of Aspirin in attempts of suicide after a marital dispute with the husband

ciprofloxacin, sharp pieces of metal reportedly inserted. The commonest cases of abortion after evaluation of the charts were incomplete 153(67%), followed by criminal 48(21.1%), then threatened 30(11.8%), inevitable 22(9.6%), complete 14(6.9%), missed 14(6.1%), and the least common is septic abortion with 8(3.5%). Their cause could have been created unskilled heath providers in rural areas as some of them were referrals, induced by self or relative because one wanted to continue with education, violence in the home leading to trauma, unsafe sex, and reproductive diseases like syphilis, HIV/AIDS, other illnesses like malaria, rape and incest, ignorance to seek medical/surgical advise after a spontaneous abortion that makes it unsafe later.

There were different methods of medical approach to the patients admitted in the hospital. These were applied depending on the type of abortion the patient had and the gestation age. For example the patients who were admitted with incomplete abortion were done Manual Vacuum Aspiration or evacuation, those with complete abortion were assessed and later discharged home on post abortion care package, those with missed abortion were done induction under Misoprostol or pitocin or done Dilation and Curettage(D&C), those with inevitable abortion were admitted and allowed to expel the products of conception spontaneously while as those with threatened abortion were allowed to take bed rest and other medications and later discharged when improved. However, those with septic abortion were initiated on strong antibiotic like ceftriaxone, metronindazole, ciprofloxacin. Intravenous fluids like normal saline and blood transfusion were considered under circumstances excessive blood loss.

In respect the above, Evacuation/D&C was the commonly used procedure with 181(61.4%) and this was not associated with any severe complications as majority of the patients were discharged when improved. This was a preferred procedure and was performed on most cases of retained products of conception in the second trimester. And as suggested by Jack Atad etal 1999, vol. 85(2), it does not require prior administration of prostaglandin E_2.

This was followed by induction using drugs such as misoprostol 53(18.0%), and it did not have association with any mortality or morbidity. This meets the conclusion laid by Joana R Pauleta etal that expectant management for incomplete abortion in the first trimester after use of Misoprostol or after spontaneous abortion may be practical and feasible, although it may increase anxiety associated with the impending abortion. The mean number of misoprostol doses used

was 2-3 sublingually/vaginally for those with missed abortion and retained products of conception undergoing induction.

Bed rest 27(9.2%) was also noted to help patients admitted with threatened abortion conserve their pregnancies together with other drugs such as sulbutamol. But this method seemed not to be effective as some patients were ending up with inevitable and complete abortion.

Blood transfusion 16(5.4%) had a very marked impact on the reservation of life of patients especially for those patients who developed anemia following abortion. But it was not clear whether this was done after immunological tests had been performed to rule the possibilities especially for those with habitual abortion. This is supported by A. Margareta Unander, vol 154(3)

Manual Vacuum Aspiration seemed to be of less use in the hospital 3(1.0%) especially in the management of incomplete abortion in the first trimester. This is not in line with the conclusion suggested by K.Mahomed etal compared Manual Vacuum Aspiration with sharp Curettage in the management of incomplete abortion at ≤12 weeks.

Explorative laparatomy was performed as an emergency procedure for a mother who was admitted with criminal abortion so as to locate the objects used in inducing abortion and the extent of trauma other organs. The records revealed only one case in four years representing 1(0.3%).

Unsafe abortion is usually associated with complications which vary in severity and also the type of abortion. In this study, anemia was noted to be commonest complications for all the types of abortion 13(54.2%). It was more severe in cases of criminal and septic types of abortion.

This was followed by post abortion sepsis 5(20.8%) and this was cited in cases that were admitted with diagnosis of septic and criminal abortion, peritonitis 3(12.5%), and perforated uterus1 (4.2%). Other complications included increased body temperature >37.9^{0}C, shock, evidence of foreign body and mechanical injury.

Risk factors for the above complications could be young age, married, and referrals from rural low level/private clinics, type of abortion (incomplete, criminal, septic) divorced/separated

families, level of education, inadequate knowledge on contraception and low level income(un employment).

The study also revealed that a big proportion of the cases spent few days of stay in the hospital that is 32.8% took two days admitted, 22.5% took only one day, 14.1% 3 days, 13.8% for 4 days, 4.9% for 5 days, 2.5% for 6-7 days and 4.0% for more than a week (>7 days). This implied that the methods used to intervene were very effective and not associated with severe complications for the respective cases, hence reducing on the period of hospitalization expenses in the hospital. This is in line with Dr Susheela Singh etal, Vol.368)

Evaluation of the charts also showed that a big proportion of the cases were discharged when fully improved, that it say 250(85.6%), 16(5.5%) of them requested for discharge against the doctors' decision, 11(3.8%) escaped from the ward, and 8(2.7%) were referred. Hence information regarding the former three categories was not clear because they were hard to follow up. A small proportion of 7(2.4%) died. The above percentage reflects the hospital's high standard to in handling maternal conditions in the catchment area.

CONCLUSIONS

Cases of all ages, social standing, employed, un employed, educated and uneducated, married and unmarried of different tribes, religion, parity, with children, of different gestation age all showed to have been associated with abortions. So it is a very common and universal phenomenon, not restricted to promiscuous or irresponsible young women as is most generally believed. But it was high in individuals of the age 20-21years.

Majority of the cases had no prior knowledge on family planning practices which could be contributing greatly to the rise in incidence of unsafe abortion in the communities.

Among all investigations done, Ultra-sound contributed significantly in directing the clinicians towards the right diagnosis for the better management of the patients in the hospital.

The most common type of abortion among others was incomplete, criminal, threatened, inevitable, complete and missed abortion.

The majority of cases observed underwent curettage and evacuation as well as induction using misoprostol for most types of abortion.

All cases admitted with unsafe abortion were associated with complication. Anemia the most common complications following abortion with others being peritonitis, perforated uterus, post abortion sepsis, high temperatures. This justifies the hypothesis.

Most of the cases admitted in hospital following unsafe incomplete, criminal, missed, threatened, inevitable, septic abortion improved and discharged back home.

RECOMMENDATIONS

Based on the study findings, the following recommendations were made:

There is need to provide family planning programs that involve men and the need to expand access to confidential, safe abortion services by well trained and skilled providers so that pregnancy termination no longer means placing women's lives and health in danger.

There is need to improve Community awareness on legal aspects, safe abortion methods, and trained providers are necessary to reduce morbidity associated with unsafe abortion.

Advocacy is needed to influence policies that will allow expanded access to safe abortion services for women of all ages and in all areas.

The hospital staff should have more training to expand on the use of Manual Vacuum Aspiration because of its efficacy and safety in incomplete abortion.

The government should equip the hospital with MVA kits and other supplies to enable it to handle conditions associated with abortion

Health campaigns should be established and extended in schools so as to address the gender and reproductive challenges.

There should mechanism put in place to prevent further complications of an unsafe procedure that has taken place already, through high quality post abortion care.

A different research should be carried on the late complications of abortion after the patients have been discharged from the hospital.

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APENDICES

APPENDIX I: CHECKLIST FOR ASSESSMENT OF THE HEALTH OUTCOMES ASSCIATED WITH UNSAFE ABORTION AMONG TEENAGERS ADMITTED IN KAMULI MISSION HOSPITAL IN THE YEAR 2010-2014

1.0 Patient identification;

a) Age [ ]
b) Next of kin [ ]
c) Address [ ]
d) Occupation [ ]
e) Yes [ ]

f) None [ ]

2.0 Marital status;

a) Yes [ ]
b) No [ ]

3.0 Parity [ ]

4.0 Occupation of the husband [ ]

5.0 Education status;

a) None [ ]
b) Primary [ ]
c) Secondary [ ]
d) Tertiary/University [ ]

6.0 Complaint on arrival to hospital

a) Excessive bleeding [ ]
b) Referral [ ]

7.0 Management in the hospital

a) Treated as outpatient [ ]
b) Admitted on ward [ ]

8.0 Treatment options;

a) Dilation & curettage [ ]
b) Blood transfusion [ ]
c) Others [ ]

9.0 Investigation(s) done

a) Hemoglobin level [ ]
b) HIV test [ ]
c) Pregnancy test [ ]
d) Blood group [ ]
e) Ultra sound [ ]

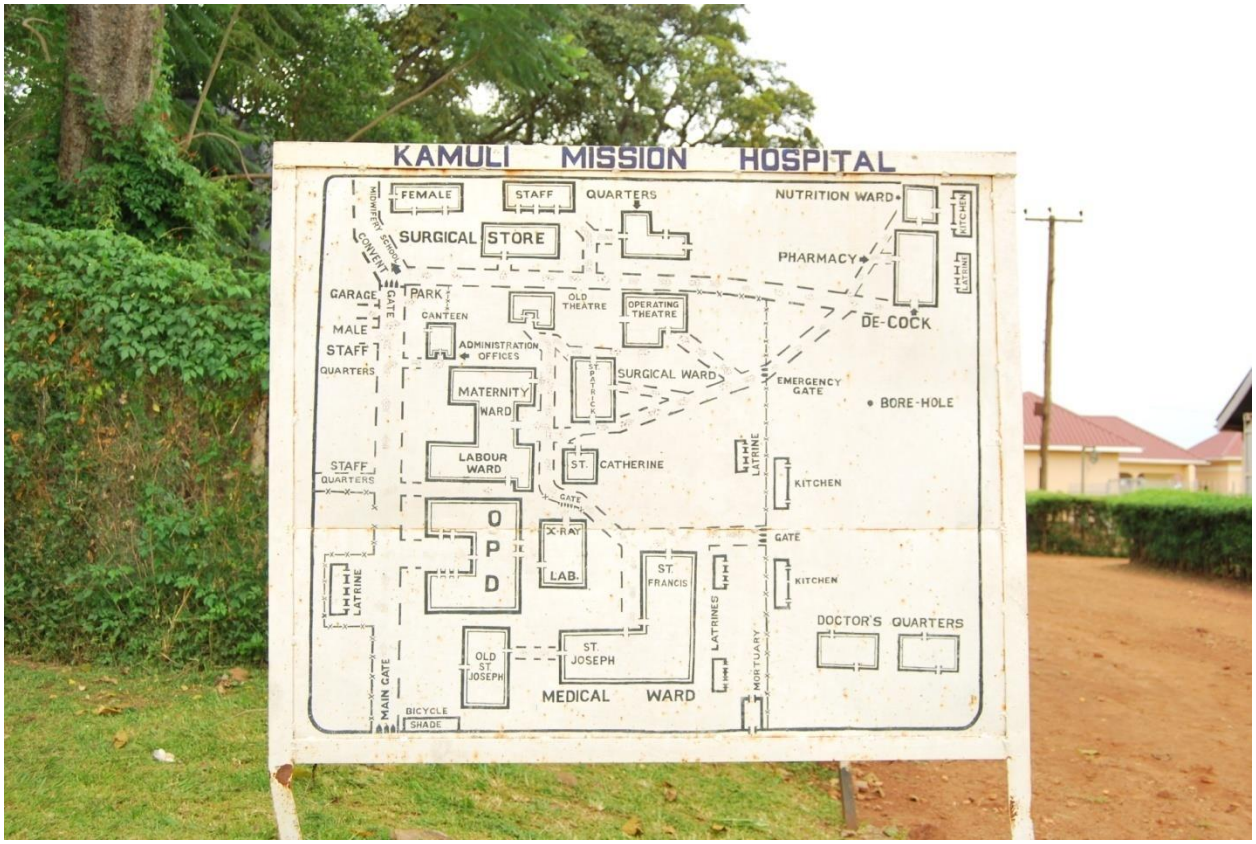
10.0 Complications later;

a) Infections [ ]
b) Severe loss of blood [ ]

11.0 Status on discharge;

a) Improved [ ]
b) Died [ ]
c) Referred [ ]
d) Escaped [ ]

Appendix 2 Map of Kamuli Mission Hospital



Appendix 3 Side views of Maternity ward