

BACKGROUND

The world witnessed the largest yearly increase of forcibly displaced people in 2022, mostly due to the increased number of people seeking refuge or asylum in other countries.[1] As of June 2023, there were over 36 million refugees worldwide, which is double the number of refugees seven years prior.[2] The social and economic turmoil that accompanies displacement put many at greater risk of sexual, physical, or psychological violence, and may result in increased gender-based violence (GBV) including rape, child marriage, or being trafficked for sexual exploitation.[3–5] It is therefore critical for refugees to have access to a full range of health services, including sexual and reproductive health (SRH) services such as birth control and abortion. In many refugee camps around the globe, however, SRH care is not prioritized or provided, making it difficult to access for many refugees.[6]

In 2022, Uganda hosted the most refugees in Sub-Saharan Africa[1] and research suggests serious gaps in access to birth control, GBV services, and abortion. One study of over 800 sexually active refugee adolescents in northern Uganda found that only 8.7% used birth control, and reported that fear of side effects was the most common reason for non-use.[7] In addition to low prevalence of birth control use, there is limited access to GBV services. According to a United Nations High Commissioner for Refugees (UNHCR) report, by the end of September 2023, over 4,000 incidents of GBV were reported among refugees in Uganda[8] yet many refugees reporting this violence likely faced a shortage of case workers to meet their legal, mental health, and psychosocial needs. The global standard ratio of GBV case workers to a case is 1:20 but this ratio is 1:85 in some Ugandan refugee settlements, possibly deterring refugees from reporting incidents of violence due to the lack of potential for follow-up care and support.[9]

Though services for GBV also include a medical follow-up, it is unclear if abortion or post-abortion care (PAC) are also provided.[8]

Abortion complications are among the top five causes of maternal mortality in Uganda[10] and though research on abortion in refugee camps is limited, one study assessing the reproductive health needs of Congolese refugees in Uganda found that ambiguous abortion policies were a barrier to accessing safe abortion and post-abortion care.[11] According to the Ugandan constitution, abortion is only legal to save the life of the mother,[12] yet a 2006 national policy guideline for SRH services states that abortion is also permitted in cases of rape, incest, severe fetal abnormalities, and if the pregnant person is HIV-positive.[13] In addition, a 2014 United Nations (UN) report noted that Uganda's law could be interpreted to allow abortion to preserve the physical and mental health of a woman, providing some protection for providers and organizations who choose to provide abortion for the clinical management of rape.[14,15] The ambiguity of the law in Uganda leads to confusion on the legality of abortion, and may prevent many from receiving the care they need.[15]

As of September 2023, Bidibidi refugee settlement hosted almost 200,000 individuals (13% of the refugee population in Uganda), making it the second largest refugee settlement in the country.[16,17] In 2022, we recruited refugees residing in Bidibidi who tried to have an abortion in the past five years to document their experiences. This brief highlights their abortion experiences, abortion incidence, and birth control use.

METHODS

We used respondent-driven sampling (a peer-to-peer recruitment strategy) to recruit girls and women, aged 15-49 years living in Bidibidi refugee settlement who have attempted to end their pregnancy in the past 5 years while in transit to, or while residing in, refugee settlements in Kenya and Uganda. This brief focuses

on the experiences of 601 refugees in Bidibidi refugee settlement in Uganda, who were recruited between July – October 2022. Participants completed a survey, and 20 also completed an in-depth interview. In addition, fifteen women of reproductive age that resided in Bidibidi were Community Advisory Board (CAB) members, and the CAB met 4 times throughout the course of the study to provide input on study development and recruitment, review initial findings, and discuss dissemination strategies. Findings were shared with various stakeholders, including CAB members, health care experts, Yumbe district officials, and members of organizations working in the SRH field. Ideas arising from discussions with community members and stakeholders are incorporated into the recommendations at the end of this brief.

Since this study used a peer-to-peer recruitment strategy, data collection was not random and may be biased toward participants with larger social networks. To address this, responses of participants with smaller networks were weighted more heavily than responses of participants with larger networks in line with established RDS methods.[18] All proportions displayed in this brief are weighted percentages using the RDS-II estimator to account for the sampling methodology.

RESULTS

Demographics

The vast majority of the 601 study participants reported South Sudan as their home country (93.7%), and most spoke Kakwa (69.9%) at home. The average age of participants was about 26 years and most (87.7%) were unemployed.

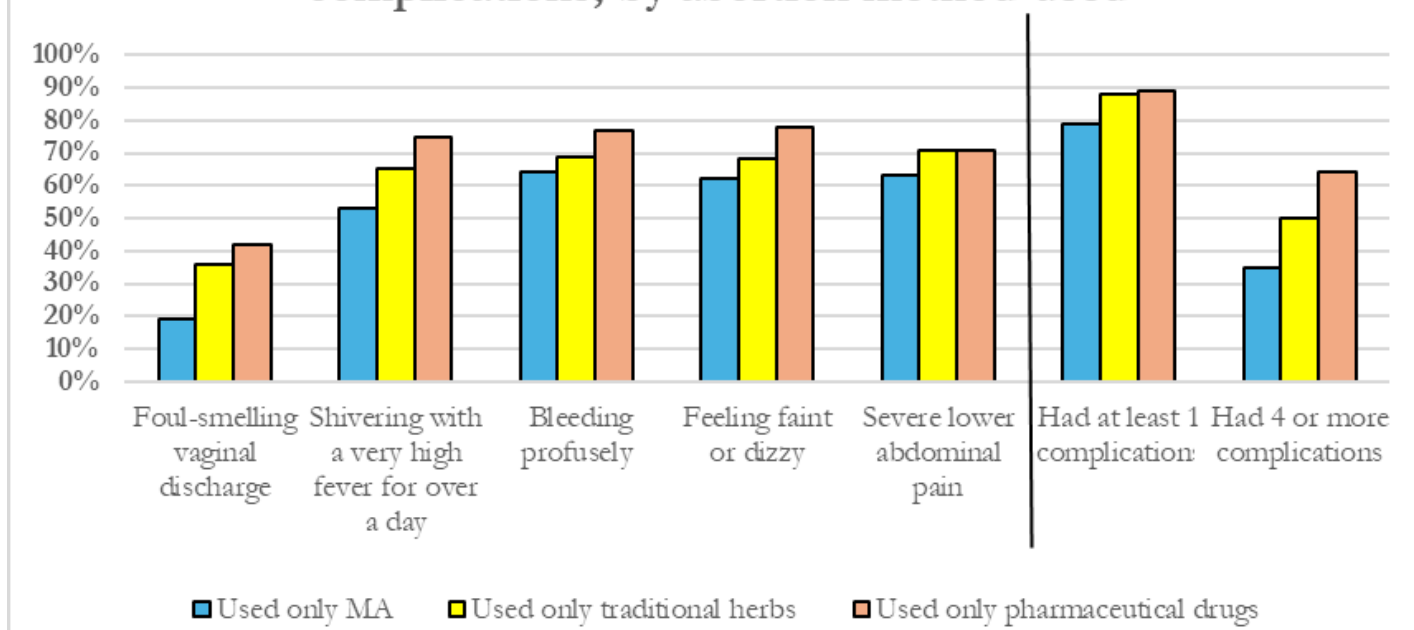
The vast majority moved to Bidibidi primarily due to war (95.6%), though some also reported leaving to seek educational opportunities (17.5%) or due to hunger (12.1%). The average amount of time refugees had been at Bidibidi was 6.1 years (range: 8 months to 36.3 years), and less than 1% reported being in the resettlement process at the time of the study. Table 1 displays participants' demographics.

Table 1: Socio-demographics of study participants (N=601)

	n	Wighted (95% CI)
Age (years)		
15-18	88	14.7 (10.7 - 18.6)
19-24	212	35.2 (30.5 - 39.9)
25-34	213	35.6 (30.9 - 40.4)
35-44	84	14 (10.8 - 17.1)
45-49	4	0.6 (0.1 - 1.1)
Home country		
South Sudan	566	93.7 (1.5 - 95.8)
Uganda	33	6 (3.9 - 8.1)
Democratic Republic of the Congo	1	0.2 (-0.1 - 0.4)
Sudan	1	0.1 (0 - 0.3)
Home language		
Kakwa	423	69.9 (65.4 - 74.5)
Other Bari dialect (Kuku, Pojulu)	63	10.6 (7.2 - 13.9)
Arabic	50	8.2 (5.7 - 10.7)
Aringa	30	5.4 (3.4 - 7.4)
Keliko	20	3.2 (1.4 - 5)
Other	15	2.7 (0.9 - 4.6)
Employment		
Unemployed	526	87.7 (84.6 - 90.7)
Employed	3	11.8 (8.8 - 14.8)
No Response	72	0.5 (-0.2 - 1.2)

Table 1 Continues on next page

Figure 2. Proportion of participants reporting complications, by abortion method used



and wanting to start or continue their education (24.0%). The vast majority reported that they themselves were involved in the decision to try and end the pregnancy (94.3%), with some reporting they also involved a friend (17.4%) or partner (5.3%). More than half (52.2%) felt they did not have all the information they needed during their abortion process or were not sure (6.0%).

The most common method used to induce an abortion was by drinking tea made with traditional herbs, such as cassava or neem leaves, (81.1%), whereas the second most common method was by using pharmaceutical drugs, including overdosing themselves with leftover medicines like malaria tablets, antibiotics, and pain medication (11.9%). Very few (5.8%) used a WHO-approved and recommended medication abortion (MA) drug such as misoprostol or a combined mifepristone and misoprostol regimen, and only 1 person reported having a manual vacuum aspiration (MVA). See Figure 1.

Despite most (94.8%) participants reporting ultimately having a complete abortion, 88.3% of respondents also reported experiencing at least one symptom indicative of a complication (see Figure 2).

Overall, over half of participants (58.3%) experienced all or almost all symptoms. Looking at complications by abortion method, half (50.1%) of refugees who used only traditional herbs (n=459) experienced all or almost all symptoms of complications whereas this was true for almost two-thirds (64.3%) of those using only pharmaceutical drugs (n=56) and 34.9% of those who used only MA (n=30).

Barriers to seeking PAC services

Despite a high proportion of people experiencing at least one symptom of a complication, less than a third (31.6%) sought treatment for these conditions or for other concerns related to their abortion. Among the participants who did not seek treatment but wanted to (39.1%), the most common reason for this decision in open-ended responses was due to fear, often of someone finding out about their abortion. Many were afraid health workers would realize they had attempted an abortion, with a few mentioning that they were specifically afraid of their abortion being reversed at the hospital. Some participants also mentioned fear of arrest. Among those who did seek treatment, most (62.5%) went to an NGO facility and sought to address concerns about pain (68.9%) and/or bleeding (44.5%) and/or to confirm termination of their pregnancy (23.3%).

Table 1 Continued: Socio-demographics of study participants (N=601)

	n	Wighted (95% CI)
Highest level of education		
Some/completed primary	423	70.5 (65.9 - 75.1)
Some/completed secondary school	114	18.5 (14.7 - 22.2)
Some college	1	0.1 (0 - 0.2)
Technical/vocational training	4	0.8 (0 - 1.6)
No schooling	59	10.1 (6.8 - 13.5)
Time lived in Bidibidi camp/settlement		
Less than a year	1	0.2 (-0.1 - 0.5)
1-4 years	39	6.6 (4.3 - 8.8)
5-9 years	541	89.8 (87.1 - 92,4)
10-14 years	4	0.6 (0.2 - 1)
15-19 years	3	0.5 (0.3-0.6)
20+ years	13	2.4 (0.7-3.9)

Displacement and experiences with violence

In the past year, 23.2% had witnessed at least one act of violence against someone in their neighborhood, including intimidation, injury, kidnapping, torture, arrest, or murder. Almost a third (32.5%) reported being physically injured by someone in the past year, and about a fifth (21.0%) reported they had been raped. About 13% reported having sex in order to eat, get shelter, or access essential services in the past year.

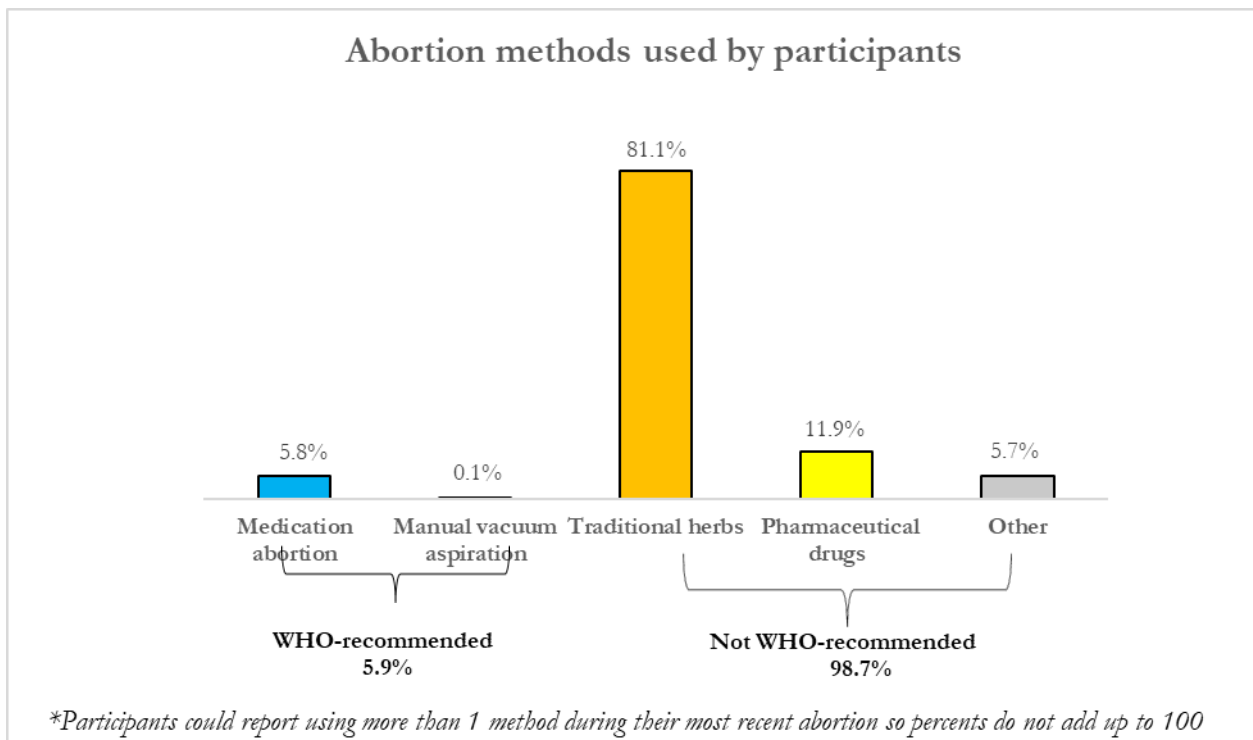
Birth control use and desired use

The majority of participants (72.1%) were not using any birth control method at the time of the survey. Those who reported using a method most frequently used the implant (13.9%) or injections (9.2%). When asked if there was a contraceptive method they would like to use in the future, the majority (83.4%) said they did not want to use any birth control method, though some reported wanting to use the implant (9.4%) and injections (5.3%).

Abortion Experiences

The most common reasons for wanting an abortion were having an unsupportive partner (59.2%), wanting to avoid the economic burden of raising a child (53.9%),

Figure 1



IMPLICATIONS AND RECOMMENDATIONS FOR EDUCATORS AND COMMUNITY MEMBERS

Unsafe abortion continues to be a leading cause of maternal mortality and morbidity in Uganda. Findings from this study revealed the majority of women and girls in Bidibidi use non-recommended methods to terminate their pregnancies, even though they may be unsafe. While safe and effective WHO-recommended drugs for abortion are available in this community, use of these methods are low. While self-managed abortion using mifepristone in combination with misoprostol or misoprostol alone is safe and effective, and a recommended model of abortion care by the WHO, [19] the vast majority of participants did not use these medications and instead relied on traditional herbs, pharmaceutical drugs, and other non-WHO recommended methods. Lack of access to safe, WHO-recommended methods of abortion and fear about using post-abortion care services delay or prevent many women and girls from receiving the urgent care they need, which may result in severe complications and deaths.

Health care educators and community members who want to share their abortion experiences can use the findings from this study to take immediate action to improve the lives of women and girls in Uganda, particularly refugees residing in Bidibidi refugee camp. We suggest:

- Health educators provide comprehensive sex education (CSE) to people of all ages and genders, including information on abortion. To reduce stigma and promote wide-spread community awareness on SRH issues, CSE should be provided to village education committees, religious and cultural leaders, model parents' groups, and school management and governing bodies. Efforts should also be made to ensure that individuals not attending school have access to CSE and/or accurate SRH information.
 - Accurate information on GBV, birth control, safe abortion methods, the dangers of unsafe abortion methods, and post-abortion care should be provided in a non-judgmental manner by community members and experts in the field countering misinformation
 - The types and range of SRH services (including but not limited to birth control, abortion, and post-abortion care, GBV services) provided at various health facilities should be available to all community members
 - Information on where to obtain accurate and comprehensive SRH information, including on abortion, in various languages, should be developed and widely shared with community members
- Individuals who have experienced GBV can share their experiences and promote community dialogue that can help prevent GBV in the future and encourage those who experience GBV to access care
- Individuals who have had an abortion can share their experiences and provide information and emotional support to others seeking safe abortion services to dispel inaccuracies and myths about abortion

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