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Abortion experiences of women and girls living in Bidibidi refugee settlement: Implications for policymakers

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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 comprehensive health services, including sexual and reproductive health (SRH) services such as contraception and abortion. In most humanitarian settings around the globe, however, serious gaps exist in the provision and prioritization of SRH care, making them unavailable or inaccessible for many refugees.[6]

In 2022, Uganda hosted the most refugees in Sub-Saharan Africa[1] and research suggests serious gaps in access to contraception, GBV services, and abortion. One study of over 800 sexually active refugee adolescents in northern Uganda found that only 8.7% used contraception, and reported that fear of side effects was the most common reason for non-use.[7] In addition to low prevalence of contraceptive 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 interpretation 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 in this humanitarian setting. This brief highlights their abortion experiences, abortion incidence, and contraceptive 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 preliminary findings, and discuss dissemination strategies. Findings were disseminated to various stakeholders, including CAB members, health care professionals, 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

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.

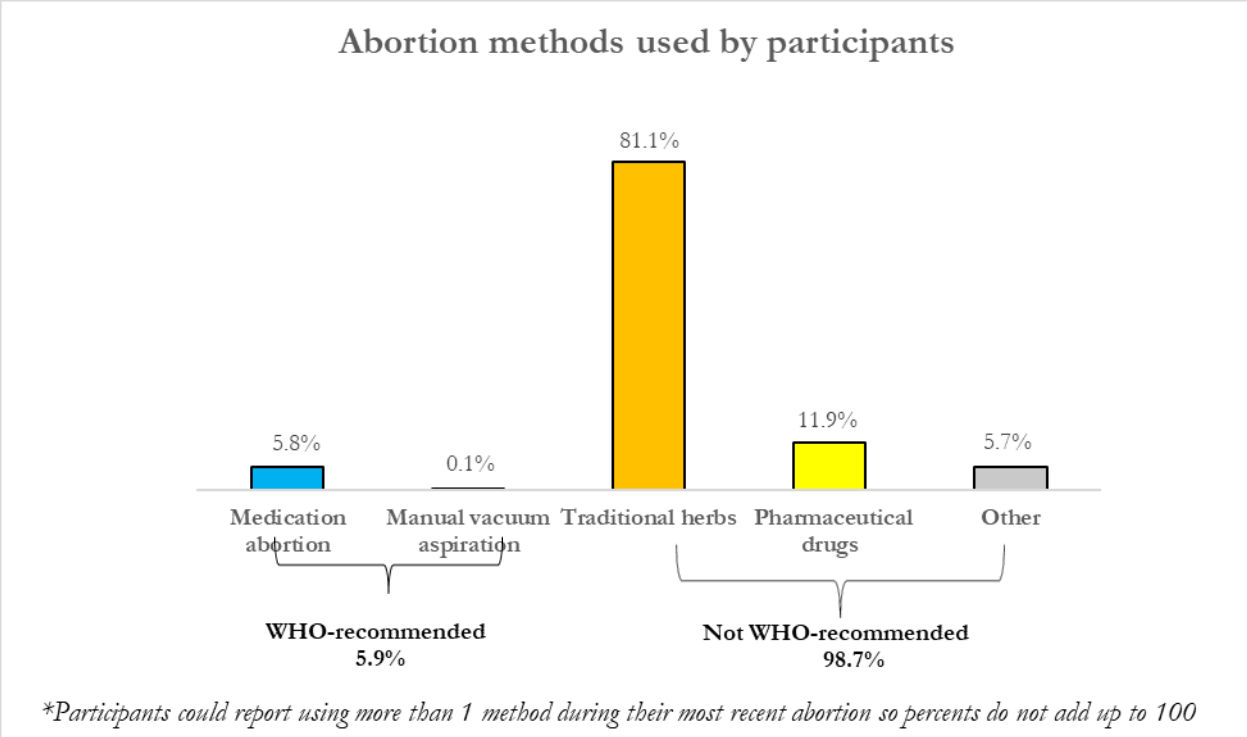
Contraceptive use and desired use

The majority of participants (72.1%) were not using any contraceptive 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 contraceptive method, though some reported wanting to use the implant (9.4%) and injections (5.3%).

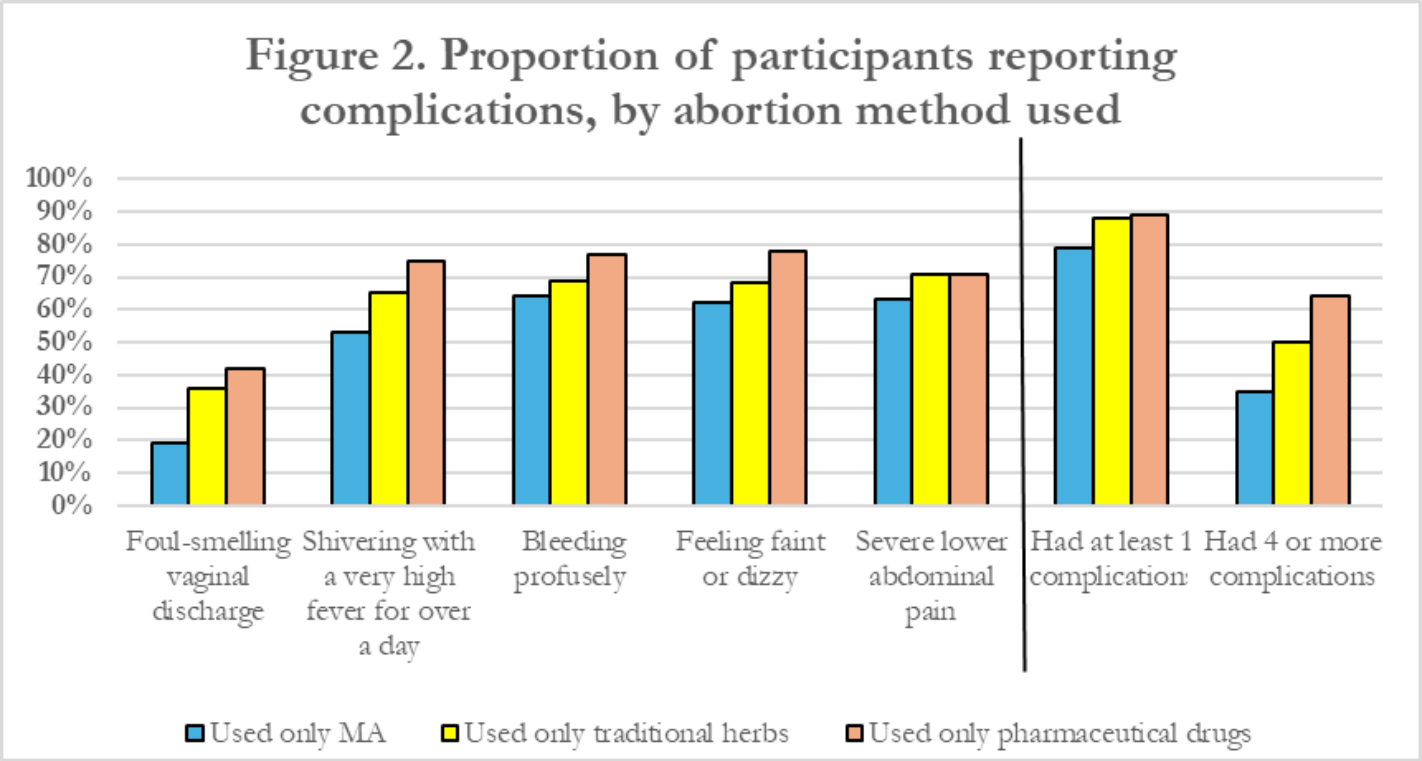
Abortion Experiences

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



**Participants could report using more than 1 method during their most recent abortion so percents do not add up to 100*



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%).

Policy Implications and recommendations

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-WHO recommended methods to terminate their pregnancies. Lack of reliable information and access to safe, WHO-recommended methods of abortion and 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. The WHO states that medication abortion can be managed by women themselves at home or other locations outside of a health care facility, which can be empowering for women.

Lack of access to safe abortion and post-abortion services is not only detrimental to the lives of women and their families, but it is also costly for the Ugandan health system and society. One study estimated that the average societal cost per induced abortion in 2010 was $177, or $64 million in annual national costs. [19] This same study also found that the largest proportion of abortion-related healthcare costs were from the treatment of complications of unsafe abortions.[19] Another study estimated that the yearly total cost of post-abortion care nationally in Uganda was $13.9 million in 2010,[20] and another estimated that providing one patient with PAC services was equivalent to about four month's income for an average person.[21] Access to safe abortion services can prevent women from suffering from complications related to unsafe abortions and reduce the need for PAC.

Policymakers should 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. While Uganda has recently added medication abortion (Combipack) to its list of essential medicines in 2023,[22] we suggest policy makers take the following actions to increase access to safe abortion services:

- Remove barriers that prevent people from accessing abortion care information and services and clarify current abortion policies
    - Revised/clarified evidence-based policies should be shared with communities with simple messaging and in multiple languages
    - Abortion should be decriminalized to:
        - Reduce fear of care-seeking and abortion stigma, which may lead women and girls to use non-recommended abortion methods and prevent them from seeking appropriate and timely follow-up care
        - Prevent health workers from providing appropriate and life-saving care
- Enact policies that require health care providers to inform survivors of sexual violence about abortion and offer abortion services in the event of unwanted pregnancy. To reduce life-threatening delays to care-seeking for unsafe abortions, ensure that policies are in place and widely known to promote reproductive autonomy, including ensuring that all women and girls may access services regardless of partner or parental consent
- Ensure that sufficient resources are allocated to health care facilities to ensure adequate numbers of qualified staff. Services should ideally be offered in multiple languages and if a translator is needed, policies should ensure that patient information remains confidential
- Introduce clinical training among Bidibidi nurses and midwives on misoprostol for post-abortion care to decrease delays to care-seeking, travel time and distance to appropriate post-abortion care
- Enact policies to make information on self-managed medication abortion safer and more widely available to increase access to safe, WHO-recommended abortion methods
    - Allow for broad legal interpretation of instances when it can be administered by health care providers
    - Increase availability of medication abortion products in pharmacies and ensure they are affordable to women and girls
    - Allocate resources for training of health care professionals on medication abortion provision, including providing adolescent-friendly and non-judgmental care to patients.

Acknowledgements

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