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Abortion experiences of women and girls living in Bidibidi refugee settlement: Implications for frontline health care workers

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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.

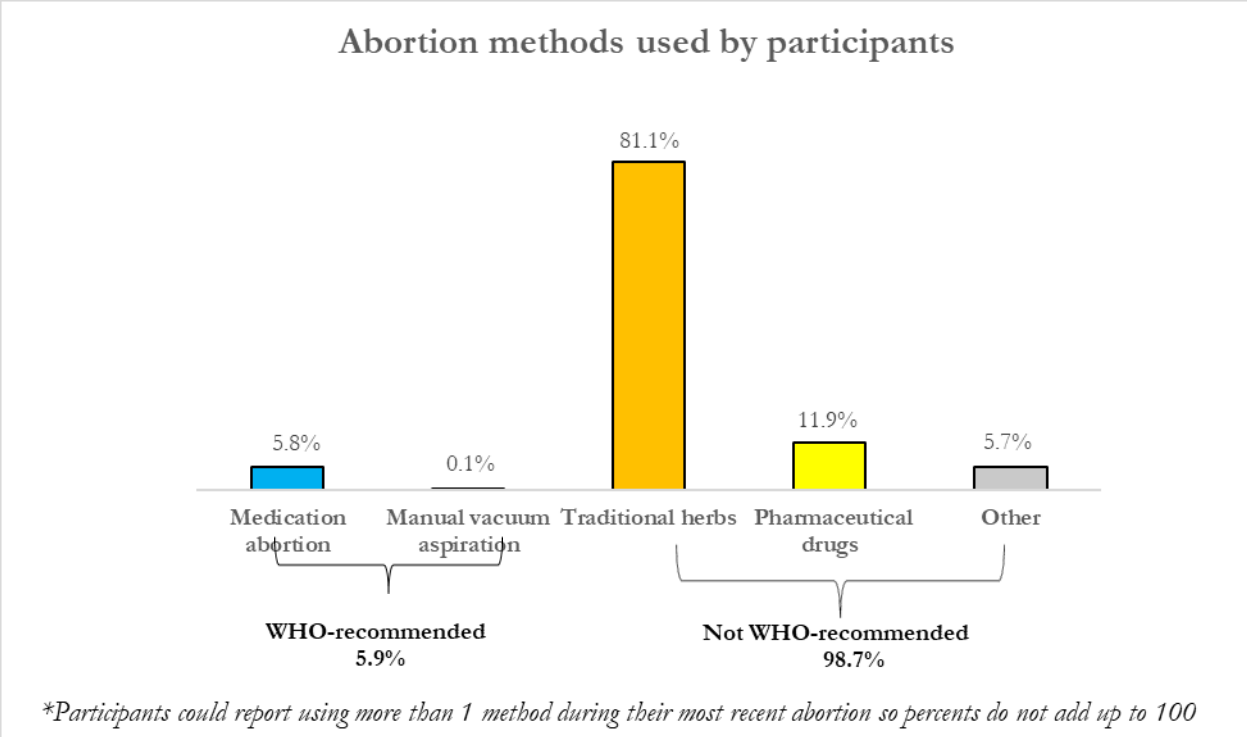
Contraceptive use and desired use

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%).

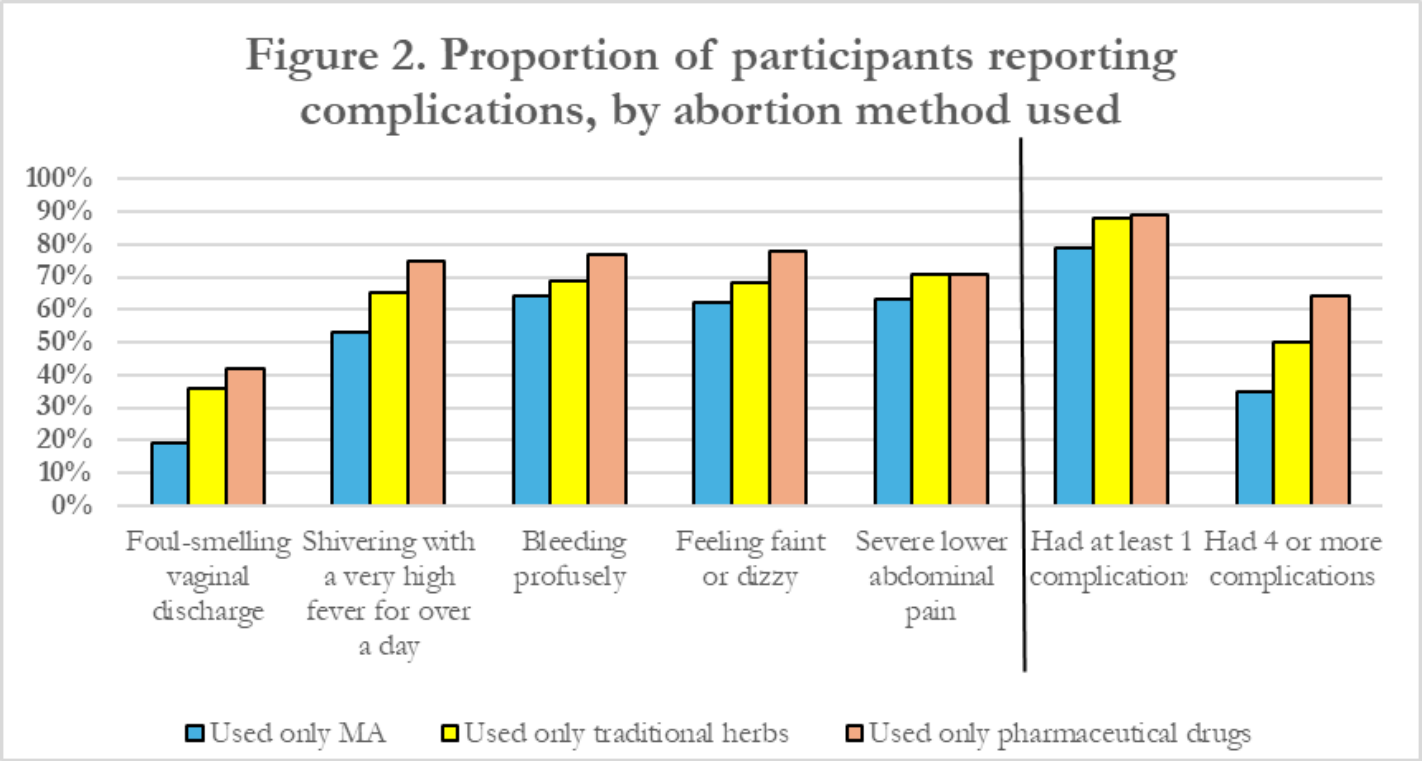
Abortion Experiences

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%).

Implications and recommendations

Although the WHO considers comprehensive abortion care (the provision of information, abortion management, and post-abortion care) an essential health care service[19] and provides guidance on safe abortion methods[20], abortion provision remains restricted in Uganda and unsafe abortion continues to be a leading cause of maternal mortality and morbidity in this country. Findings from this study revealed the majority of women and girls in Bidibidi use non-WHO recommended methods to terminate their pregnancies. Many study participants attempted to self-manage their abortion at home. 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[21], the vast majority of participants did not use these medications and instead relied on traditional herbs, pharmaceutical drugs, and other non-WHO recommended methods. Many participants in our study also experienced signs of abortion complications. Though some cramping, bleeding, fever, chills, nausea, and discolored or foul-smelling vaginal discharge may be common after an abortion[22–24], intense or prolonged symptoms may be indicative of an infection, internal injury, or incomplete abortion.[25] Lack of 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.

Health care providers and health facilities 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 who have little opportunity to make their voices heard. We suggest:

- Midwives and health care providers at both private and public health care facilities should be trained in how to provide safe abortion care with WHO-recommended medications
- High quality post-abortion care with misoprostol and MVA should be provided as close as possible to women in the communities where they live
- No woman or girl should be criminalized or fear criminalization for seeking accurate and reliable information on safe medication abortions or for seeking post-abortion care for complications resulting from miscarriage or unsafe abortion
- No woman or child should be forced into motherhood; survivors of sexual violence should be counseled appropriately on all of the potential health impacts of rape, including the possibility of an unwanted pregnancy. Safe and legal abortion should be described as an integral component of the clinical management of rape for survivors
- Health care providers should ensure that SRH care be patient-focused, patient-driven, and provided in a non-judgmental manner
    - Patients, regardless of age or gender, should be able to receive contraceptive and abortion services without the knowledge or consent of others (including parents and partners)
    - Health facilities and providers should strive to create a non-judgmental, welcoming environment for patients of all ages seeking sexual and reproductive health services
    - Patients should be the primary decision-makers about the care they receive and should not be shamed for their questions or decisions
    - Information on GBV, contraception, and abortion should be offered and provided to all patients seeking such information, in multiple languages
    - A referral should be made if the provider is unable to offer a SRH service a patient is seeking. A list/network of where/who to refer for SRH services should be developed and accessible to all providers.

Acknowledgements

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