FACTORS ASSOCIATED WITH SELF-INDUCED ABORTIONS AMONG WOMEN OF REPRODUCTIVE AGE (15-49) YEARS IN JINJA REGIONAL REFERRAL HOSPITAL- JINJA CITY

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DECLARATION

I, **Arongat Esther Omoding**, hereby declare that to the best of my knowledge, this dissertation is my original work and that it has never been submitted to any other institution for any academic award. Where the work of others is used in the study, it has been duly acknowledged.

Signature: ..... Date: 7.2.2026

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APPROVAL

This is to certify that this dissertation was written under my guidance as supervisor and is submitted to the School of Public at Uganda Christian University for approval.

Signed:  Date: 7. 2.2026

DR. OKELLO SAMUEL MOSES

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ABSTRACT

This study aimed to investigate the factors associated with Self-induced abortions among women of reproductive age of 15-49 years in Jinja regional referral hospital- Jinja city. The specific objectives were to determine the behavioural factors associated with self-induced abortions, examine the socio-demographic factors associated with Self-induced to Abortions and to establish the reproductive health behavioural factors associated with Self-induced Abortions among women of reproductive age of (15-49) years in Jinja Regional Referral Hospital. The quantitative cross-sectional study design. Krejcie and Morgan's (1970) method was used to draw a sample size of 327 women, from a population of 2,200 women of reproductive age of (15-49) years in Jinja Regional Referral Hospital

The sample was selected using a systematic random sampling technique and the data was entered in SPSS version 23 for analysis. The validity and reliability of data was verified using the content validity index and the Cronbach alpha coefficient. For descriptive purposes, the researcher used the mean and standard deviation to analyse the data. Data was tested for correlation to establish the association between the study variables. Using inferential statistics, the data was analysed for regression to establish the predictor power of variables on the outcome variable. The study findings demonstrated a significant correlation between Self-Induced Abortion, Socio-Demographic Factors, Reproductive Health Behaviours, and Abortions among women of reproductive age of (15-49) years. The regression results revealed that self-managed abortion, socio-demographic factors, and reproductive health behaviour significantly predict self-induced abortion among (15-49-year-old women at a 1% significance level. Factors like self-induced abortion, socio-demographic factors, and reproductive health behaviour account for 44.8% of Self-induced abortion among (15-49) year old women, while other factors account for 55.2%.

The study recommends that Health educators should collaborate with community leaders to educate women aged 15-49 on self-management techniques, contraceptive access, and reproductive health rights. They should lobby for financial aid for abortion services, advocate for flexible work hours and paid leave, and implement comprehensive sexual health education programs. Regular health check-ups can help address misconceptions and promote safe practices.

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OPERATIONAL DEFINITIONS

Termination of Pregnancy: - Abortion involves the intentional ending of a pregnancy before the fetus is able to survive outside the uterus.

Medical Procedure: - Abortion can be performed through various medical procedures, such as medication abortion (using pills) or surgical abortion (invasive procedures like aspiration or dilation and curettage).

Maternal Mortality: - is the death of a woman during pregnancy or within 42 days of termination, influenced by pregnancy-related factors and is a crucial indicator of maternal healthcare quality and women's overall well-being during the reproductive period.

Maternal Morbidity: - is the health conditions or complications that arise during pregnancy, childbirth, or the postpartum period.

Safe abortion: - is the termination of a pregnancy in a manner that is safe, legal, and without causing harm to the woman's health. It is the use of medical procedures or medications to end a pregnancy in a controlled and regulated environment.

Induced abortion: - intentional termination of pregnancy using drugs/ sticks or surgical intervention after implantation and before the embryo or fetus has become independently viable

Unwanted/Unintended pregnancy: - Is getting unplanned or unintended pregnancy.

Contraceptives: - variety of methods used to prevent pregnancy.

Reproductive age: - the ages when females are most fertile and most likely to bear children for this study women of reproductive age are from 15-49years.

Self-managed abortion: - is ending a pregnancy without direct supervision from a clinician at the time, often outside a formal healthcare facility.

Self-managed abortion techniques: - are ways a person ends a pregnancy without direct supervision from a clinician, usually outside a formal healthcare setting.

LIST OF ACRONYMS

AIDS: - Acquired Immune Deficiency Syndrome

ANC: - Antenatal Care

CVI: - Content Validity Index

HIV: - Human Immunodeficiency virus

JRRH: - Jinja Regional Referral Hospital

SPSS: - Statistical Package for Social Sciences

UBOS: - Uganda Bureau of Statistics

WHO: - World Health Organization

CHAPTER ONE

1.1.Introduction

This chapter consist of the background of the study, problem statement, and purpose of the study, objectives of the study, research questions, scope of the study, and significance of the study.

1.2 Background of the study

According to the World Health Organization (WHO) abortion is defined as pregnancy termination prior to 20 weeks' gestation. Also, Radanović and Mijatović (2024), assert that, abortion is the termination of pregnancy, while reproductive autonomy is an essential human right, allowing individuals to control their contraceptive use, pregnancy, and childbearing (Senderowicz, 2020). However, this is not the case for many women, with global estimates indicating that nearly half (121 million) of pregnancies that occur annually are either mistimed or unwanted (Bain, Zweekhorst, & de Cock Buning, 2020). Despite this, global unintended pregnancy rates have decreased over time, but the proportion ending in abortion has increased (Bain, Zweekhorst, & de Cock Buning, 2020).

In United States of America, African-American and Latina women suffer from misconceptions surrounding contraception, its use and efficacy (Carvajal, Bevilacqua, Caldwell, & Zambrana, 2023). Also, the cultural beliefs posed a barrier to the use of contraception (Carvajal, et al., 2023). Besides, more than half of unintended pregnancies end in induced abortion, and the global abortion rate from 2015 to 2022, was 39 abortions per 1,000 women of reproductive age 15–49 years (Troutman, Rafique & Plowden, 2020). In Bangladesh, Bishwajit, Tang, Yaya, and Feng (2017), found that 13.5% of rural women with unmet contraceptive needs experienced unwanted pregnancies, with 30% describing their last pregnancy as unintended (Bishwajit, et al., 2017).

Like any other African countries, in Ghana, Owoo, Lambon-Quayefio, and Onuoha, (2019) assert that, women from lower socioeconomic backgrounds face challenges in accessing reproductive healthcare services including contraception and safe abortion services. This contributed to higher rates of abortion (Owoo, et al., 2019). Also, Aladago, Boakye-Yiadom, Asaarik, and Aryee, (2019), opine that about 71% of the nearly 200 000 abortions in Nigeria in 2019 were illegal. Besides, Aladago, et al., (2019), in their study found that although safe abortion is legal in Nigeria, it is not available on request which is a barrier for women of reproductive age of 15-49 years.

In East Africa, unsafe abortion remains a significant public health issue in the region, leading to high rates of maternal mortality and morbidity (Guttmacher Institute, 2020). Also, Remez, Mayall, and Singh (2020), asserts that 35 per 1,000 women of reproductive age have had an induced abortion each year. While abortions rarely result in medical complications when conducted in accordance with internationally accepted standards, only 24% of abortions that occur in East Africa are classified as safe (Qureshi, et al., 2021). Also, Ushie, et al., (2019), opine that Kenya's strict laws on abortion and finite access to safe reproductive healthcare services are causing women to engage in unsafe abortion practices.

Laws in Uganda firmly criminalize abortion, allowing for the termination of pregnancy. Preeclampsia, eclampsia, cervical cancer, HIV/AIDS positive women choosing to terminate, incest, and rape, conditions incompatible with extra urine life such as encephally that put the mother's life at risk, as set out in the Penal Code Act (1995). Kagaha, and Manderson (2021), agrees that ambiguous legislation and policy surrounding abortion have fostered an ongoing dispute among healthcare providers, law enforcement officials, judges, women and girls regarding their interpretation. Despite this legal ambiguity and the associated risks of inconsistent application, the country actively enforces abortion laws (Kagaha, & Manderson, 2021). Also,

Hauger (2023), demonstrates that many Ugandan women turn to risky abortion procedures as a result of legal constraints on the procedure and the significant unmet need for contraception, frequently seeking help from unskilled clinicians in covert clinics.

Lloyd, Haussman, and James (2019), assert Ugandan women often resort to unsafe abortion practices due to legal restrictions and unmet contraceptive needs, often seeking help from untrained providers in clandestine clinics. According to Wenyira (2019), inadequate information about reproductive health and contraception, lack of awareness among women, limited access to quality reproductive healthcare services in Busoga region. Also, Kimera (2019), assert that inadequate knowledge about reproductive health and family planning has led to unsafe abortion practices in Jinja hospitals over the past decade. However, representative research exploring the factors associated with abortions among women of reproductive age of 15-49 years in Ugandan is inadequate, which this study seeks to address.

1.3 Problem Statement

No one has the authority to terminate the life of an unborn child except as may be authorized by law (Constitution of the Republic of Uganda, 1995). The clinical indication by law includes, preeclampsia, eclampsia, and fetal abnormalities not compatible with extra-uterine life, anencephaly, cervical cancer, Rape, incest, defilement and HIV positive women requesting termination. According to Uganda Bureau of Statistics (UBOS, 2023), each year, an estimated 297,000 induced abortions are performed in Uganda, and nearly 85,000 women are treated for complications. Besides, abortions occur at 54 per 1,000 women aged 15–49 and account for one in five pregnancies. The rate of abortion is higher than average in the Central region (62 per 1,000 women), the country's most urban and economically developed region. It is also high in the Busoga region (70 per 1,000). Nationally, about half of pregnancies are unintended; 51% of married

women aged 15–49 and 12% of their unmarried counterparts have an unmet need for effective contraceptives (UBOS, 2023). Also, Namagembe, Nakimuli, Byamugisha, Moffett and Aiken (2022), highlights that the problem of unintended pregnancy perseveres due to lack of access to sexual and reproductive health services and information, and finite use of contraception. In Uganda, only 41.4% of all women aged 15–49 years are using a contraceptive method (Achom, 2023). Furthermore, in 2021, over 26% of all reproductive aged women in Uganda were estimated to have unmet needs for family planning, hence unwanted pregnancies leading to abortions. According to Kibira, et al., (2023), the main drivers of abortion were linked to unstable relationships and male partner's behavior exhibited soon after being informed about the pregnancy with 32.5% of the women reported that the men deny responsibility for the pregnancy. Despite the government of Uganda enforcing law against abortion, Jinja Regional Referral Hospital abortion rate is at 15.8%. The high abortion rate is perhaps largely due to factors such as limited access to reproductive healthcare including access to contraceptive methods, poverty, economic instability, sociocultural norms, religious beliefs, and inadequate sexual education. Therefore, this study sought to assess the factors associated with self-induced abortions among women of reproductive age (15-49) years in Jinja regional referral hospital, Jinja city

1.4 Purpose of the Study

The purpose of the study was to examine the factors associated with access to Abortions among women of reproductive age of 15-49 years in Jinja Regional Referral Hospital.

1.5 Objectives of the study

i. To determine the behavioral factors associated with self-induced abortions among women of reproductive age of 15-49 years in Jinja Regional Referral Hospital.

ii. To examine the socio-demographic factors associated with self-induced Abortions among women of reproductive age of 15-49 years in Jinja Regional Referral Hospital

iii. To establish the reproductive health behavioral factors associated with self-induced Abortions among women of reproductive age of (15-49) years in Jinja Regional Referral Hospital

1.6 Research questions

i. What are the behavioral factors associated with self-induced abortions among women of reproductive age of 15-49 years?

ii. What is the socio-demographic factors associated with self-induced Abortions among women of reproductive age of 15-49 years?

iii. What is the reproductive health behavioral factors associated with self-induced Abortions among women of reproductive age of 15-49 years?

1.7. Justification for the Study

Uganda has one of the highest rates of unsafe abortions globally, with an estimated 54% of abortions being unsafe, leading to severe health complications and maternal deaths (Qureshi, et al., 2021). Understanding the factors contributing to unsafe abortions is crucial for developing targeted interventions to minimize maternal mortality and enhance reproductive health outcomes in Uganda.

Unsafe abortions pose significant risks to women's health, including complications such as hemorrhage, infection, and uterine perforation, which can lead to long-term physical and psychological consequences (WHO, 2022). The lack of research on the factors influencing unsafe abortions among women in Uganda, including socio-cultural, economic, and healthcare barriers,

could lead to ongoing maternal deaths and severe health complications, hindering efforts to improve reproductive health outcomes.

1.8. Significance of the study

Understanding the factors associated with abortions among women of reproductive age in Uganda, particularly within the context of Jinja Regional Referral Hospital, is significant for improving women's health outcomes.

The findings of this study can inform policy and advocacy efforts focused on reforming restrictive abortion laws and advocate for the implementation of comprehensive reproductive healthcare policies that uphold women's reproductive rights and improve access to safe abortion care.

Evaluating the quality and accessibility of abortion services at JRRH provides valuable insights into the strengths and weaknesses of the healthcare system in addressing women's reproductive health needs. Therefore, the findings can inform efforts to strengthen healthcare infrastructure, improve provider training, and enhance the delivery of comprehensive reproductive healthcare services, not only at the study site but also across Uganda.

It also adds to the body of scientific knowledge on reproductive health and the findings will contribute to the evidence base for designing and implementing effective interventions to reduce unsafe abortions, improve maternal health outcomes, and promote reproductive health and rights globally.

1.9 The Scope of the Study

1.9.1 Geographical scope

The study was conducted in Jinja Regional Referral Hospital, Jinja City offering a localized understanding of factors associated with abortions in Uganda's Eastern region. This was because of the high abortion cases in Jinja City (UBOS, 2023).

1.10 Conceptual Framework

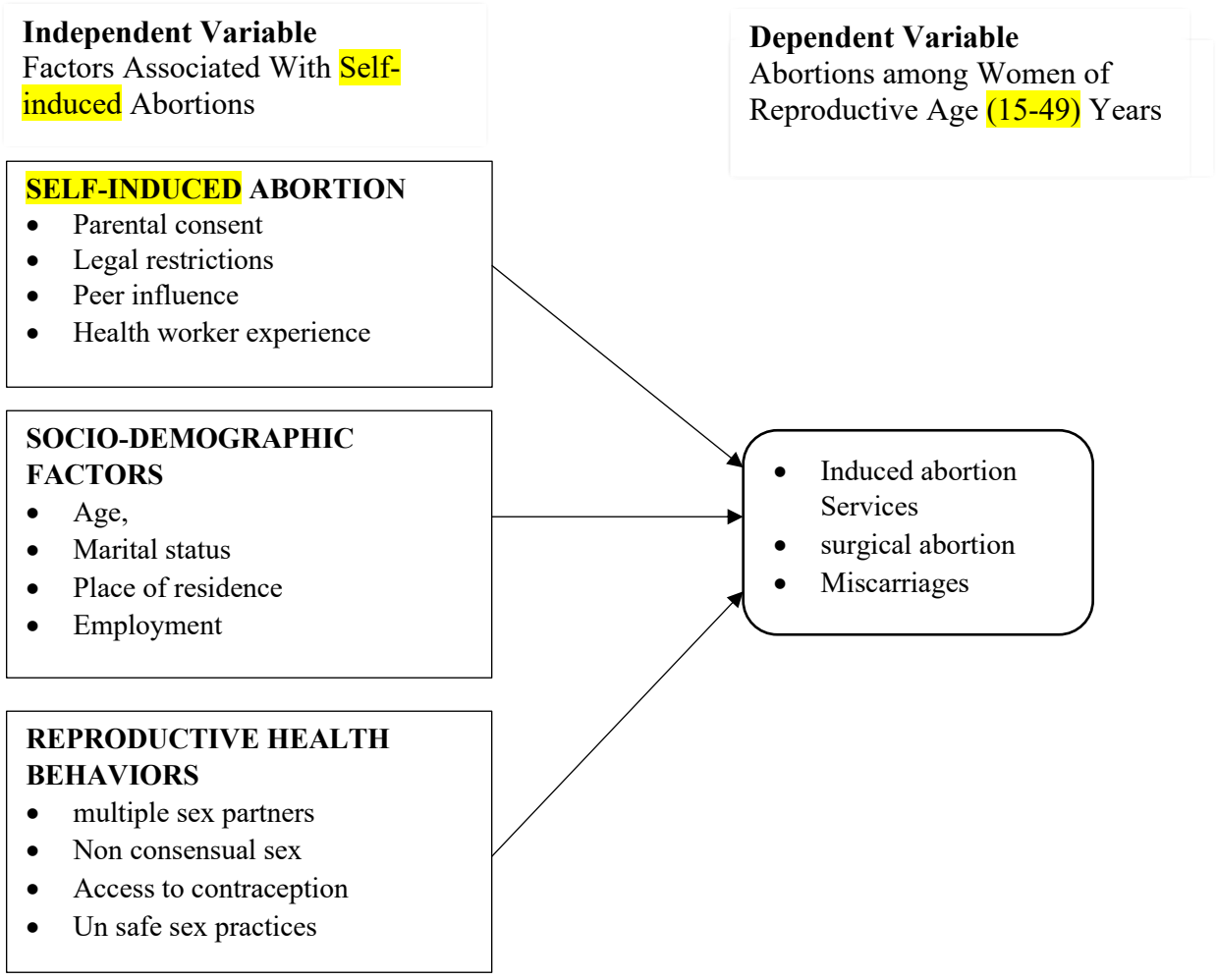

Figure 1: A conceptual Framework.

Source: *Adopted and modified from the literature of* (Bain, Zweekhorst, & de Cock Buning, 2020; Moseson, et al., 2020; and Sopheab, Tuot, Chhea, & Gorbach, 2015).

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

The chapter presents literature reviewed from the works written by other scholars on factors associated with self-induced abortions among reproductive aged women (15-49 years) in jinja regional referral hospital, jinja city. The section also contains the factors influencing self-induced abortions, socio-demographic factors associated with self-induced abortions and reproductive health behavioral factors associated with self-induced abortions among women in reproductive ages of 15-49 years.

2.1 Theoretical Framework-Behavioral theory

Behavioral theory, is a framework that explains human behavior primarily as a response to external stimuli rather than internal thoughts or emotions, emphasizing observable actions over mental processes (Wang, 2025). Behavior is learned through environmental interactions, adhering to conditioning principles: classical conditioning (Pavlov) involves associations between neutral and meaningful stimuli (Medjadi, 2024). Behavioral theory assumes that all behaviors positive, negative, adaptive, or maladaptive are acquired through experience and can be modified systematically by manipulating environmental contingencies (Brown, Price, & Dombrovski, 2023).

In the context of self-induced abortion among women of reproductive age, behavioral theory helps to explain why certain women might engage in unsafe abortion practices despite knowing potential health risks (Getahun, et al., 2023). For instance, women's decisions to self-induce abortion may be influenced by observed behaviors within their social networks, perceived social norms, or

reinforcement they have received, either positive (perceived solution to unwanted pregnancy) or negative. This aligns with behavioral theory's emphasis on the role of learned behaviors and environmental factors in shaping actions.

The theory is particularly relevant for understanding individual-level determinants such as knowledge of abortion methods, attitudes toward contraception, perception of pregnancy risk, and personal experiences with healthcare access (Kim, & Steinberg, 2023). Behavioral theory supports the identification of factors like peer influence, perceived benefits versus barriers, self-efficacy in managing reproductive health, and prior exposure to health information all of which are critical in analyzing why women might resort to self-induced abortion (Jargin, & Robertson, 2025). It allows researchers to conceptualize that behavior (self-induced abortion) is not random but a result of learned responses, perceived outcomes, and environmental interactions.

However behavioral theory is less relevant for structural or systemic determinants that also contribute to self-induced abortion (Osasona, 2025). Societal factors like legal restrictions, economic constraints, healthcare availability, cultural norms, and gender inequality impact societal understanding, which behavioral theory alone, focusing on individual cognition and learned behavior, cannot fully address (Hayden, 2022). For instance, a woman may have high self-efficacy and knowledge about safe abortion methods but still opt for unsafe self-induced abortion due to lack of access to healthcare or fear of legal consequences, factors beyond her personal behavior patterns. Therefore, while behavioral theory illuminates individual choice, it does not adequately capture broader social, legal, and economic determinants (Liscow & Markovits, 2022).

In developing the conceptual framework for this study, behavioral theory provides a structured way to classify and link variables (Calder, He, & Sternthal, 2023). The framework can be designed to reflect how individual knowledge, attitudes, perceptions, and past experiences (behavioral

determinants) interact with social and environmental factors to influence the likelihood of self-induced abortion (Shukla, et al., 2022). For example, the framework can map out pathways showing how perceived severity of an unwanted pregnancy, perceived barriers to safe abortion, peer influence, and self-efficacy may predict the behavior of self-induced abortion. By doing so, behavioral theory helps researchers identify key mediators and moderators, such as educational interventions, peer counselling, or access to reproductive health services, which can be targeted to prevent unsafe abortion practices (Burnette, et al., 2023).

In conclusion, behavioral theory is highly relevant in explaining the individual-level cognitive and social determinants of self-induced abortion, supporting the development of a conceptual framework that links knowledge, attitudes, and perceived behavioral control to the outcome.

2.1 The behavioural factors associated with Self-induced Abortions among women in reproductive ages (15-49) years.

According Adama, Natacha, Alexi, Sibraogo and Charlemagne (2024) limited access to safe and legal abortion services is a significant factor contributing to self-induced among women in Uganda. Kagaha and Manderson (2020), opine that restrictive abortion laws and lack of access to healthcare facilities offering safe abortion services push women to resort to self-induced methods, often resulting in serious health complications and mortality. Besides, Brown, Laverde, Barr-Walker and Steinauer (2022), assert that societal stigma and shame associated with abortion contribute to women's decisions to opt for self-induced abortion methods. A study by Huang, and Ngai (2022), opine that the fear factor of judgment and discrimination faced by women seeking abortion services, leading them to choose clandestine abortion methods to avoid stigma and social repercussions.

Furthermore, Darko Okyere (2022), asserts that limited knowledge about safe abortion methods and available healthcare services leads some women to resort to self-induced methods. Research by Harries Daskilewicz, Bessenaar and Gerdts (2021) indicated that women may not be cognizant of the available safe and legal abortion services or may lack information about the risks and complications linked to self-induced abortion methods. According to Bolin, Whelehan, Vernon and Antoine (2021), economic factors, such as poverty and inability to afford healthcare services, contribute to self-induced abortion among women. Studies by du Plessis and Macleod (2024) highlights that women from lower socio-economic backgrounds may choose self-induced methods due to financial constraints, viewing them as a more affordable option compared to seeking professional medical care for abortion services.

Studies by Hammond and Moretti (2023) highlighted that fear of legal repercussions and criminalization of abortion lead women to choose self-induced abortion methods in secrecy, without seeking professional medical assistance or support. Houck (2024), asserts that women lacking social support networks and those facing pressure from partners or family members may resort to self-induced abortion methods. Furthermore Kumar, Agrawal, Chaurasia and Ponnusamy (2024), indicated that women may choose self-induced abortion methods due to the lack of support or coercion from partners or family members, leading to isolation and increased health risks. Further, Pleasure, Becker, Johnson, Broussard and Lindberg (2024), opine that misinformation and myths surrounding abortion contribute to women's decisions to opt for self-induced abortion methods.

The factors influencing self-induced s among women of reproductive age in Uganda are complex and shaped by socio-economic, cultural, legal, and healthcare-related factors. Addressing these factors can be through targeted interventions and policies that target improving access to safe and

legal abortion services, reducing stigma, and increasing awareness about reproductive rights and healthcare options which is crucial for preventing unsafe abortions and improving reproductive health outcomes for women in Uganda. However, more research is needed to explore the multifaceted nature of these factors and their implications for women's health and well-being.

2.2 Socio-Demographic Factors Associated with Self-induced Abortions among Women of Reproductive Age (15-49) Years.

According to Tang, Ibrahim and Shorey (2024), abortion remains a significant public health concern globally, with a substantial impact on women's health and well-being. A study by Nathan, Berglas, Kaller, Mays, and Biggs (2023) found that younger women, particularly adolescents, were more likely to seek abortions due to unintended pregnancies, often attributed to limited access to contraception and lower levels of reproductive health knowledge. According to Baffour-Duah, Shimange-Matsose and Olorunfemi (2023), marital status has been pointed out as a significant socio-demographic factor influencing abortion decisions among women.

Thabrew, Ranawaka and Ranamukhaarachchi (2024), agree that unmarried women, including those in consensual unions or cohabiting relationships, were more likely to seek abortions compared to married women, often due to concerns about social stigma and economic constraints associated with raising a child out of wedlock. Besides, Giorgio, Makumbi, Kibira, Shiferaw and Sully (2023), adds that educational attainment has been consistently linked to abortion-seeking behavior among women.

Furthermore, Kibira, et al., (2023), asserts that highly educated women are more likely to have access to information about contraception and reproductive health services, thud lower rates of unintended/unplanned pregnancies and subsequent abortions compared to women with lower

levels of education. Also, Koiwa, Shishido and Horiuchi (2024), argue that geographic location and access to healthcare services also influence abortion-seeking behavior among women in Uganda. Further, Bell, Oumarou, Alzouma and Moreau (2023), highlight that that women in urban areas were more likely to have access to comprehensive reproductive healthcare services, inclusive of safe abortion services, compared to women in rural/remote areas, where access to healthcare facilities may be limited.

Napier-Raman, et al., (2024), points out that religious and cultural beliefs shape attitudes towards abortion and influence women's decision-making processes in Uganda. Adherence to religious beliefs, particularly among Catholic and Protestant communities, often deterred women from seeking abortions, leading them to resort to unsafe abortion methods or clandestine abortions. Also, Motwani (2023) brings to attention that women with higher parity, especially those already burdened with caring for multiple children, were more likely to seek abortions due to concerns about their ability to provide for additional children and maintain their livelihoods. Additionally, Mahanaimy and Moseson (2023) asserts that the presence of social support networks, including family, friends, or community organizations, can influence women's decisions regarding abortion. Women with strong support networks may feel more empowered to seek abortion care and may have access to resources that facilitate the process, such as transportation or financial assistance. Therefore, the socio-demographic factors like; age, marital status, education, income, residential area, religion, and parity play significant roles in shaping abortion-seeking behavior among women of reproductive age in Uganda. Understanding these factors is essential for developing targeted interventions and policies for improving access to comprehensive reproductive healthcare services, reducing unintended pregnancies, and preventing unsafe abortions in Uganda. However, there is

need for more research to explore the complex interplay of these socio-demographic factors and their implications for women's reproductive health outcomes in Uganda.

2.3. The Reproductive Health Behavioural Factors Associated with self-induced Abortions among Women of Reproductive Age (15-49) Years.

Contraceptive use is a key reproductive health behavior that impacts abortion-seeking behavior among women. Women who use contraception consistently are less likely to experience unintended pregnancies reducing the need for abortions (Atiglo, & Biney, 2023). Also, Gelassa, Tafasa and Kumera (2023), assert that utilization of antenatal care (ANC) services is associated with better pregnancy planning and management, which can reduce the likelihood of unintended pregnancies and subsequent abortions. Women who attend ANC visits are more likely to receive information and support related to contraception and family planning, leading to lower rates of unintended pregnancies and abortions (Gelassa, Tafasa & Kumera, 2023). Further, Niland and Nearchou (2023), strongly emphasize that comprehensive sexual health education plays a crucial role in shaping reproductive health behaviors among women.

Furthermore, Millanzi, Osaki and Kibusi (2023), emphasize the importance of providing accurate and culturally sensitive sexual health education to empower women with the skills and knowledge to make well-informed decisions about contraception, pregnancy, and abortion. Vizheh, Zurynski, Braithwaite and Rapport (2024), points out that Partner involvement and communication regarding reproductive health decisions influence women's access to safe abortion services. Additionally, women who have supportive partners and open communication about reproductive health issues are more likely to seek timely and safe abortion care, compared to those who face partner opposition or lack of support (Vizheh, Zurynski, Braithwaite & Rapport, 2024). Also, Koiwa, Shishido and Horiuchi (2024), indicates that women with a history of previous pregnancies,

especially those ending in abortion, may be more likely to seek abortions in subsequent pregnancies due to factors such as contraceptive failure or limited access to family planning services.

Dozier et al., (2020) points out that religious and cultural beliefs surrounding reproduction, sexuality, and abortion can shape women's attitudes and behaviors regarding abortion. Societies with strong religious or cultural taboos against abortion may stigmatize women who seek abortion services, leading them to delay or avoid seeking care altogether. Furthermore, Jim, Magwentshu, Menzel, Küng, Van Rooyen and Pearson (2023) adds that Stigma and discrimination related to abortion can have profound effects on women's reproductive health behaviors and access to abortion services. Fear of judgment, social ostracization, or legal repercussions may deter women from seeking abortion care, leading them to resort to unsafe practices. Therefore, reproductive health behaviors, including contraceptive use, ANC utilization, sexual health education, partner involvement and communication, previous pregnancy experiences, and decision-making autonomy, are closely linked to abortion-seeking behavior among women of reproductive age of 15- 49 in Uganda.

Addressing these factors through targeted interventions and policies is essential for improving access to comprehensive reproductive healthcare services, reducing unintended pregnancies, and preventing unsafe abortions in Uganda. However, there is need for further research to explore the complex interplay of these reproductive health behaviors and their implications for women's reproductive health outcomes in Uganda.

CHAPTER THREE

METHODOLOGY

3.0. Introduction

This chapter covers the methodology; study design, study area, study population, sample size determination, sampling technique, data collection method, data collection tools, data collection procedure, data analysis and presentation, and ethical considerations.

3.1 Study Design

This study used a quantitative cross-sectional study design. According to Maier, Thatcher, Grover, & Dwivedi, (2023), cross-sectional study design is a research approach used to capture information based on data gathered for a specific point in time and the data gathered is from a pool of participants with varied characteristics and demographics known as variables. This study used a cross-sectional design using only a quantitative approach because it provided a one-off opportunity to capture data, saving time and resources (Amin, 2005; Martins, Romeiro & Caldeira, 2017). A quantitative cross-sectional study design also allowed the researcher to collect data from a diverse group at a single point in time. This provided a snapshot of the population's attitudes, beliefs, and behaviors related to abortions among women in their reproductive ages of 15-49 years in Jinja Regional Referral Hospital.

3.2 Area Location and rationale for the choice

The study was conducted in Jinja Regional Referral Hospital, Jinja City and it is chosen as the study setting to investigate the factors associated with Abortions among reproductive aged women (15-49) years. This was due to the fact that Jinja Regional Referral Hospital, located in Jinja City, serves as a hub for numerous women of reproductive age (15–49 years) seeking antenatal care, as well as for many cases of post-abortion care, making it a convenient location to access a diverse

group of women of reproductive age (15–49) years who utilized the hospital for healthcare services. Besides, the JRRH catered to a population that was reflective of the broader community in terms of demographics, socioeconomic status, and healthcare-seeking behaviors.

3.3 Study Population

According to Welman and Kruger (2004), population is defined as the study object, which may include individuals, groups, organizations, events, or the conditions to which they are uncovered. The study population was women in their reproductive ages of (15-49) years from diverse socio-economic backgrounds and geographical locations that seek care in Jinja Regional Referral Hospital, Jinja City.

3.4 Sample Size Determination.

Sample size is the number of respondents or observations included in a study (Memon, et al., 2020). To determine the sample size the researcher employed the Krejcie and Morgan table of sample size determination (1970), which is displayed in the table below, see (Appendix III). This served as a guide for choosing the final sample from each woman of reproductive age of (15-49) years. According to Jinja regional Referral Hospital Report (2024), 2,200 women of reproductive age of (15-49) years visit the facility per year. Therefore, from a population of 2,200 women of reproductive age of 15-49 years, 327 women constituted the sample size for the study. e=0.05 is the permissible error margin. This guaranteed the generalizability of the study results to the broader population of women aged 15-49 in the area. Therefore, by conducting the study at Jinja Regional Referral Hospital in Jinja City, the researcher was able to gain insights into the healthcare-seeking behaviors of women of reproductive age (15–49 years) and how these behaviors influenced abortion decisions for women of reproductive age (15–49 years).

3.4.1 Sampling Procedure

According to Etikan, Musa and Alkassim (2016), systematic random sampling is a stereological tool, which provides a framework to quickly build an accurate estimation of the distribution of objects or classes within an image, whilst minimizing the number of observations required. Simple random sampling was employed to select the study participants by first defining the target population as women of reproductive age (15–49 years) attending Jinja Regional Referral Hospital, Jinja City, during the study period. Using this approach, the researcher determined a sampling interval based on the estimated number of eligible women and the required sample size of 327, after which a starting point was randomly chosen. Simple random sampling is executed by first defining the target population and creating a complete list of all its members, then selecting a sample so that every individual has an equal and independent chance of being chosen. This is typically done using a random number generator, or computer software to pick participants from the list without bias. Subsequently, every eligible woman who was available and willing to participate was selected and invited to complete the questionnaire until the desired sample size was achieved. This technique, adapted from stereological principles, enabled efficient coverage of the study population while minimizing selection bias and reducing the number of observations required, thereby ensuring an accurate and representative estimation of the characteristics of the larger population (Kato et al., 2020; Soranno et al., 2020).

3.5 Inclusion and Exclusion criteria

3.5.1 Inclusion criteria

According to Keung, McElroy, Ladner, and Grubbs (2020), inclusion criteria are specific characteristics or conditions that participants must possess in order to be eligible to participate in a study. These criteria help researchers define the target population and ensure that the study results

are applicable to a specific group of interest (Andel, et al., 2020). The study comprised women who had either requested or undergone an abortion, who were between the ages of 15 and 49, and who had come to the gynecology/maternity ward at Jinja Regional Referral Hospital. The research also involved women who were willing to participate, as well as women who were seeking care at Jinja Regional Referral Hospital and came from a variety of backgrounds, including ethnic and religious backgrounds, varying socioeconomic situations, and diverse geographic areas.

3.5.2 Exclusion criteria

Exclusion criteria are specific conditions that disqualify individuals from participating in research or receiving a treatment, ensuring safety and effectiveness (Blasini et al., 2023). These may include age, medical conditions, medications, and previous treatments, thereby ensuring valid and reliable study results. This research excluded women who were under the age of 15 or above 49, women who had not sought or undergone an abortion, women who refused or were unable to take part in the research, women who were detained or institutionalized, and women with severe mental health conditions that may have affected their ability to provide accurate information.

3.6. Data Collection Procedures

Structured questionnaires were developed to collect data on factors related to abortions among women of reproductive age of 15-49 years in Jinja Regional Referral Hospital. Upon proposal approval, an introductory letter was obtained from Uganda Christian University to show that the data was collected for academic purposes. Also, permission was sought from the Jinja Regional Referral Hospital, Jinja City, to acquire access to the respondents in the gynecology ward of the hospital. The researcher personally administered the questionnaires to the target group, which consisted of women in their reproductive ages of 15-49 years seeking care at Jinja Regional Referral Hospital, Jinja City.

3.7. Validity and Reliability of Research Instruments

3.7. 1 Validity of Research Instruments

Validity in a study involves ensuring instruments accurately measure what they are supposed to (Amin, 2005). To ensure validity, instruments were developed, assessed using the content validity index, and pre-tested with 15 women aged 15-49 at Jinja Regional Referral Hospital (Cresswell, 2004). The validity measurement analysis produced by the content validity index computation used the expert judgment formulae below.

$$\text{CVI} = \frac{\text{Number of items regarded relevant}}{\text{Total number of items}} \times 100$$

Table 3.1 Measurement of Authenticity

	Number of questions	Valid questions	Content Validity Index (CVI)
Abortions among Women of Reproductive Age of 15-49 Years	15	14	0.933
Self-induced Abortion	20	18	0.900
Socio-Demographic Factors	20	17	0.850
Reproductive Health Behaviors	20	18	0.900
Average			0.896

Source: Primary source, (2024)

From the table 3.1 above, all the CVIs were above 0.7, indicating that the items were relevant to the study variables. On average, the content validity index was 0.896, which was in agreement with Amin (2005), who recommended that for any tool to be considered valid the CVI has to be 0.7 and above.

3.7.2 Reliability of Research Instruments

Reliability is the extent to which the measurement instruments produce consistent scores when the same groups of individuals are measured repeatedly under the same conditions (Amin, 2005). Reliability was calculated using Cronbach's coefficient alpha to test for internal consistency. The researcher administered questionnaires to the target group who were women of reproductive age of 15-49 years that sought care at the Referral Hospital. According to Cronbach (1950), coefficient values of 0.7 and above are considered acceptable and coefficients yield above 0.8 are considered very good (Madan & Kensinger, 2017). Therefore, the threshold that the researcher considered was 0.7 and above.

Table 3.2 Measurement of Reliability

Variables	Cronbach's Alpha	Number Of Items
Abortions among Women of Reproductive Age of 15-49 Years	0,724	15
Self-Managed Abortion	0.704	20
Socio-Demographic Factors	0.721	20
Reproductive Health Behaviors	0.755	20

Source: *Primary Source, (2024)*

The Cronbach's alpha reliability coefficient of 0.724 indicates a good level of internal consistency for Abortions among Women of Reproductive Age of 15–49 Years. This suggests that the 15 items used to measure this construct are closely related and reliably assess the same underlying concept. Self-Managed Abortion has a Cronbach's alpha reliability coefficient of 0.704, which also indicates a good and acceptable level of internal consistency. This implies that the 20 items included in this scale are sufficiently correlated and provide a reliable measurement of the construct. Additionally, Socio-Demographic Factors recorded a Cronbach's alpha reliability

coefficient of 0.721. This value reflects a good level of internal consistency, meeting the commonly accepted threshold of 0.7 for reliable measurement instruments. Reproductive Health Behaviors yielded a Cronbach's alpha reliability coefficient of 0.755, which is the highest among the variables listed. This suggests a stronger internal consistency, indicating that the 20 items used effectively measure reproductive health behaviors. In general, the reliability coefficients indicate that the measurement instruments used to assess Abortions among Women of Reproductive Age of 15–49 Years, Self-induced Abortion, Socio-Demographic Factors, and Reproductive Health Behaviors demonstrate acceptable to good levels of reliability, making them suitable for the study.

3.8 Data Management

Data management is a critical aspect of any research study, ensuring that data is collected, stored, processed, and analyzed in a systematic and secure manner (Nazir, et al., 2020). SPSS version 23 was used to present data by generating tables and frequency tables.

3.9 Data Analysis

Data analysis is the process of collecting, coding and analyzing data using various statistical and logical methods and techniques to extract relevant information from the data (Ibrahim, 2015). Data collected was sorted, edited, coded, and entered into the computer using SPSS 23. This helped the researcher to present data by generating tables and frequency tables. At the univariate level, SPSS assisted the researcher in generating descriptive statistics, such as means. Descriptive statistics were used to summarize data in an organized manner by describing the factors related to self-induced abortions among women of reproductive age (15-49) years in a sample or population (Kaur, Stoltzfus, & Yellapu, 2018). The analysis of the data that was collected was also done with the help of SPSS version 23, and the study findings were presented using tables. The method of

data analysis used was descriptive analysis. Overall, the assumptions of linear regression were reasonably met, indicating that the model estimates are reliable.

3.10 Ethical Considerations

Prior to data collection, ethical clearance was obtained from the department of Research and Ethic Committee (REC) of Uganda Christian University, UG-REC-026 in Appendix IV. In addition, permission to conduct the study was obtained from Jinja Regional Referral Hospital.

This study considered confidentiality, which was a pertinent ethical issue to be put into practice. Respondents were entitled to confidential treatment of all information they provided on personal matters; the researcher also took ethical concerns about copyright respect and ownership of intellectual property into account to avoid plagiarism while referring to other people's studies. Anonymity was also considered, where individuals were regarded as anonymous. Names and other forms of identification were excluded from the tool. The researcher sought the respondents' consent to participate in the study and at the same time assured them that their participation was voluntary. All the participants were assured and informed of confidentiality and that the information they provided would be used only for research purposes.

The results of the study will be used strictly for academic purposes and policy relevant discussions aimed at addressing self-induced abortion among women of reproductive age (15-49) years. The findings will be disseminated in the Manner that protects participants anonymity and respects community integrity. The study outcomes are intended to contributed to evidence based intervention to improve access to abortion without causing harm or misrepresentation of Jinja Regional Referral Hospital and the study results will be shared with the Jinja Regional Hospital and the results will be shared with Jinja Regional Referral Hospital.

CHAPTER FOUR
PRESENTATION AND INTERPRETATION OF FINDINGS

4.1 Introduction

This chapter covers the analysis and findings of the research. It broadly categorizes the analyses and discussions about Factors Associated with Self-induced Abortions among Women of Reproductive Ages (15-49 Years) in Jinja Regional Referral Hospital- Jinja City.

4.2 Demographic characteristics of the respondents

4.2.1 Response rate

A total of 327 Ugandan women aged 15-49 provided information to a targeted sample at Jinja Regional Referral Hospital, resulting in a 100% response rate.

Table 4.1 Response rate and demographic distribution of women respondents of reproductive age (15-49) years in Jinja Regional Referral Hospital.

Age bracket	Frequency	Percent
15-24years	86	26.3
25-34years	124	37.9
35- 44years	92	28.1
45- Plus, years	25	7.6
Total	327	100
Level of Educational		
No education	45	13.8
Primary	27	8.3
O-Level	112	34.3
A-Level	53	16.2

Diploma	78	23.9
Bachelor's degree	12	3.7
Total	327	100

Source: *Primary data (2024)*

4.2.2 Age Diversity

The Age bracket in the table 4.1 above, shows a mixed distribution of participants across age groups, with younger women comprising the majority. The 25-34 age group, comprising 37.9%, is the largest demographic, with reproductive health issues being significant. The 35-44 age group, comprising 28.1%, is also significant, with reproductive health issues being relevant. The 15-24 age group, comprising 26.3%, is the largest, with women aged 15-24 having different reproductive health needs.

4.2.4 Levels of Education

From the table 4.1 above, 34.3% of population has achieved O-Level education. This indicates that a substantial number of individuals have completed secondary education. A notable percentage of individuals, 23.9%, have attained a Diploma, suggesting that there is a segment of the population engaged in post-secondary education. The presence of 16.2% of individuals with A-Level qualifications indicates a continued path toward further academic opportunity, reflecting a group that may be poised to enter higher education. The percentages for individuals with No Education (13.8%) and Primary (8.3%) highlight a considerable portion of the population that lacks formal schooling. This raises concerns about their ability to access information and services, including those related to health and reproductive rights. The Bachelor's Degree holders constitute only 3.7% of the population, suggesting limited access to higher education among the surveyed individuals.

This low percentage indicates possible barriers, such as socio-economic status, that prevent higher education attainment. The community faces a significant knowledge gap in understanding complex health information, particularly reproductive health and rights. This can lead to higher risks of self-induced abortions and unintended pregnancies. Integrating educational initiatives with health services is crucial for improving health literacy and empowering marginalized populations.

The inclusion of participants from diverse educational backgrounds underscores the presence of a broad range of education levels within the sample, thereby highlighting the overall diversity of the participants. The dataset offers valuable insights into the diversity of educational backgrounds among participants, which has the potential to significantly influence the study's findings

4.3 Empirical findings

On a 5-point Likert scale, respondents' opinions were scored as follows: 1. Strongly disagree (SD) 2. Disagree (D) 3. Not sure (NS) 4. Agree (A) 5. Strongly agree (SA)These results are shown below in accordance with the study's goals:

4.3.1 Abortions among Women of Reproductive Age (15-49) Years

Table 4. 2: Opinions of respondents on Induced Abortion Services

Induced Abortion Services	Percentage Response (%)						
	SD	D	N	A	SA	Mean	Std dev
I easily access induced abortion services	8.3% (27)	10.1% (33)	9.2% (30)	51.4% (168)	21.1% (69)	3.67	1.160
I have ever used medication and induction abortion to abort the foetus	17.7% (58)	15.3% (50)	10.1% (33)	41.9% (137)	15.0% (49)	3.21	1.357
There costs involved in accessing induced abortion services	4.3% (14)	8.6% (28)	12.2% (40)	47.1% (154)	27.8% (91)	3.86	1.054

I am aware of the potential risks and complications associated with induced abortion procedures	11.6% (38)	12.5% (41)	10.7% (35)	41.9% (137)	23.2% (76)	3.53	1.291
The societal attitudes and stigmas impact access to induced abortion services	2.1% (7)	3.7% (12)	11.0% (36)	56.3% (184)	26.9% (88)	4.02	.849

Source: *Field data 2025*

Table 4.2 shows that respondents generally perceive induced abortion services as accessible, though experiences and awareness vary. A majority (51.4%, 168) strongly agreed they can easily access services (mean = 3.67, SD = 1.16), while 27.6% (90) disagreed. Regarding personal use, 41.9% (137) reported ever using medication or induction abortion, compared with 43.0% (141) who had not (mean = 3.21, SD = 1.36). Most recognized costs as a factor, with 74.9% (245) agreeing or strongly agreeing that services incur expenses (mean = 3.86, SD = 1.05). Awareness of potential risks was moderate (65.1% agreeing or strongly agreeing, mean = 3.53, SD = 1.29), while societal attitudes and stigma were seen as highly influential (83.2% agreeing or strongly agreeing, mean = 4.02, SD = 0.85).

Table 4. 3: Opinions of respondents on Surgical Abortion

Surgical Abortion	**Percentage Response (%)**						
	SD	**D**	**N**	**A**	**SA**	**Mean**	**Std dev**
The gestational age of the pregnancy affects the choice of surgical abortion method	1.8% (6)	4.3% (14)	5.8% (19)	50.5% (165)	37.6% (123)	4.18	.861
The cost of surgical abortion varies based on the method and healthcare provider	14.1% (46)	12.8% (42)	11.6% (38)	41.3% (135)	20.2% (66)	3.41	1.323

Healthcare providers provide counselling and support for individuals undergoing surgical abortion	1.5% (5)	8.3% (27)	8.0% (26)	45.3% (148)	37.0% (121)	4.08	.956
Access to surgical abortion services vary in urban and rural areas	3.4% (11)	2.1% (7)	6.1% (20)	58.7% (192)	29.7% (97)	4.09	.860
The ethical considerations surrounding surgical abortion impact healthcare practices	4.9% (16)	2.8% (9)	8.3% (27)	49.5% (162)	34.6% (113)	4.06	.989

Source: *Field data 2025*

Table 4.3 indicates strong agreement that multiple factors influence surgical abortion practices. Gestational age was a key determinant, with 88.1% (288) agreeing or strongly agreeing that it guides method choice (mean = 4.18, SD = 0.861), as providers tailor procedures to minimize complications. Access and service availability were similarly important, with 88.4% (289) noting urban-rural disparities (mean = 4.09, SD = 0.860), as services are often concentrated in urban centers. Counselling and support were widely reported, with 82.3% (269) agreeing that providers offer guidance to help patients make informed choices (mean = 4.08, SD = 0.956). Ethical considerations also shaped practice, with 84.1% (275) acknowledging their influence on procedure decisions and patient care (mean = 4.06, SD = 0.989). Cost showed greater variability, with 61.5% (201) agreeing that fees differ by method and provider (mean = 3.41, SD = 1.323).

Table 4. 4: Opinions of respondents on Miscarriages

Miscarriages	**Percentage Response (%)**						
	SD	**D**	**N**	**A**	**SA**	**Mean**	**Std dev**
I have had miscarriage in childbirth	6.4% (21)	9.2% (30)	7.6% (25)	52.3% (171)	24.5% (80)	3.79	1.108

Lifestyle factors influence the risk of experiencing a miscarriage	15.0% (49)	13.8% (45)	5.2% (17)	46.2% (151)	19.9% (65)	3.42	1.350
Healthcare providers diagnose and manage miscarriages	4.0% (13)	11.6% (38)	7.6% (25)	50.8% (166)	26.0% (85)	3.83	1.065
There are medical treatments available for individuals experiencing recurrent miscarriages	13.8% (45)	12.5% (41)	6.7% (22)	45.3% (148)	21.7% (71)	3.49	1.329
Societal beliefs around miscarriages influence the support and care provided to individuals	2.1% (7)	6.1% (20)	8.3% (27)	53.8% (176)	29.7% (97)	4.03	.905

Source*: Field data 2025*

Table 4.4 shows generally high agreement on miscarriage knowledge, management, and societal influences, with mean scores from 3.42 to 4.03. The strongest agreement was on the impact of societal beliefs on support for those experiencing miscarriage, with 83.5% (273) agreeing or strongly agreeing (mean = 4.03, SD = 0.905). Similarly, 76.8% (251) agreed that healthcare providers effectively diagnose and manage miscarriages (mean = 3.83, SD = 1.065) and reported personal experience with miscarriage (mean = 3.79, SD = 1.108). Agreement was slightly lower for the availability of treatment for recurrent miscarriage (67.0%, mean = 3.49, SD = 1.329) and lifestyle factors influencing miscarriage risk (66.1%, mean = 3.42, SD = 1.350), reflecting some uncertainty.

4.5 Empirical findings

On a 5-point Likert scale, respondents' opinions were scored as follows: 1. Strongly disagree (SD) 2. Disagree (D) 3. Not sure (NS) 4. Agree (A) 5. Strongly agree (SA)These results are shown below in accordance with the study's goals:

4.5.1 The behavioral factors associated with self-induced abortions among women of reproductive age (15-49) years

Table 4. 5: Opinions of respondents on Parental Consent

Parental Consent	Percentage Response (%)						
	SD	**D**	**N**	**A**	**SA**	**Mean**	**Std dev**
There are potential barriers faced by minors seeking self-induced abortion without parental consent	2.1% (7)	4.6% (15)	4.6% (15)	51.7% (169)	37.0% (121)	4.17	.875
Healthcare providers navigate the issue of parental consent in self-induced abortion for minors	14.1% (46)	10.7% (35)	12.8% (42)	46.2% (151)	16.2% (53)	3.40	1.275
The ethical considerations surrounding parental consent in self-induced abortion	1.2% (4)	8.0% (26)	6.7% (22)	42.2% (138)	41.9% (137)	4.16	.945
The lack of parental consent impacts the safety and access to resources for individuals seeking self-induced abortion	2.8% (9)	5.5% (18)	9.5% (31)	49.5% (162)	32.7% (107)	4.04	.944
I make informed decisions about self-induced abortion in the absence of parental consent	1.5% (5)	4.6% (15)	7.0% (23)	54.1% (177)	32.7% (107)	4.12	.841

Source: *Field data, 2025*

Table 4.5 indicates generally high agreement regarding issues of parental consent in self-induced abortion among minors, with mean scores ranging from 3.40 to 4.17. The strongest agreement was that minors face potential barriers when seeking self-managed abortion without parental consent, with 88.7% (290) agreeing or strongly agreeing (mean = 4.17, SD = 0.875). High agreement was also observed for ethical considerations surrounding parental consent (84.1%, 275; mean = 4.16, SD = 0.945), informed decision-making in the absence of parental consent (86.8%, 284; mean = 4.12, SD = 0.841), and the impact of lack of parental consent on safety and access to resources (82.2%, 269; mean = 4.04, SD = 0.944). Agreement was comparatively lower on how healthcare

providers navigate parental consent in self-induced abortion for minors, with 62.4% (204) agreeing or strongly agreeing (mean = 3.40, SD = 1.275), suggesting greater uncertainty or variability in perceptions of provider practices.

Table 4. 6: Opinions of respondents on Legal Restrictions

Legal Restrictions	Percentage Response (%)						
	SD	**D**	**N**	**A**	**SA**	**Mean**	**Std dev**
The legal restrictions on self-induced abortion methods in different countries	4.0% (13)	7.3% (24)	8.0% (26)	52.6% (172)	28.1% (92)	3.94	1.006
Legal restrictions impact access to safe and reliable information on self-induced abortion	14.4% (47)	12.2% (40)	11.3% (37)	41.3% (135)	20.8% (68)	3.42	1.331
Legal restrictions on self-induced abortion affect marginalized communities and individuals with limited access to healthcare	4.3% (17)	8.6% (28)	12.2% (25)	47.1% (168)	27.8% (89)	3.87	1.070
Legal restrictions on self-managed abortion intersect with other reproductive rights issues, such as access to contraception and sexual education	12.5% (41)	14.4% (47)	9.5% (31)	43.1% (141)	20.5% (67)	3.45	1.305
Advocacy efforts are in place to challenge and reform legal restrictions on self-managed abortion	4.6% (15)	4.9% (16)	6.1% (20)	50.8% (166)	33.6% (110)	4.04	1.004

Source: *Field data, 2025*

Table 4.6 indicates generally high agreement regarding the effects of legal restrictions on self-induced abortion, with mean scores ranging from 3.42 to 4.04. The strongest agreement was that advocacy efforts are in place to challenge and reform legal restrictions, with 84.4% (276) of respondents agreeing or strongly agreeing (mean = 4.04, SD = 1.004). High agreement was also

observed for the view that legal restrictions on self-induced abortion methods exist across countries (80.7%, 264; mean = 3.94, SD = 1.006) and that such restrictions disproportionately affect marginalized communities and those with limited healthcare access (74.9%, 257; mean = 3.87, SD = 1.070). Agreement was comparatively lower regarding the impact of legal restrictions on access to safe and reliable information (62.1%, 203; mean = 3.42, SD = 1.331) and their intersection with other reproductive rights issues such as contraception and sexual education (63.6%, 208; mean = 3.45, SD = 1.305), suggesting greater variability in perceptions in these areas.

Table 4. 7: Opinions of respondents on Peer Influence

Peer Influence	**Percentage Response (%)**						
	SD	**D**	**N**	**A**	**SA**	**Mean**	**Std dev**
Peer influence impact the decision-making process of individuals considering self-induced abortion	1.8% (6)	2.4% (8)	5.8% (19)	52.9% (173)	37.0% (121)	4.21	.806
Peer networks and online communities play in providing support and information on self-induced abortion	14.4% (47)	14.1% (46)	14.4% (47)	42.8% (140)	14.4% (47)	3.29	1.281
Peer experiences and testimonials influence individuals' perceptions and attitudes towards self-induced abortion	4.3% (14)	7.0% (23)	5.2% (17)	48.6% (159)	34.9% (114)	4.03	1.034
Healthcare providers engage with peer networks to provide accurate information and resources on self-induced abortion	0.9% (3)	5.5% (18)	7.6% (25)	54.1% (177)	31.8% (104)	4.10	.830
Peer pressure and social norms within peer groups affect	2.1% (7)	7.6% (25)	7.3% (24)	49.8% (163)	33.0% (108)	4.04	.950

individuals' choices regarding self-induced abortion							

Source: *Field data, 2025*

Table 4.7 indicates generally high agreement on the role of peer influence in self-induced abortion decision-making, with mean scores ranging from 3.29 to 4.21. The strongest agreement was that peer influence impacts individuals' decision-making, with 89.9% (294) agreeing or strongly agreeing (mean = 4.21, SD = 0.806). High levels of agreement were also observed for the influence of peer experiences and testimonials (83.5%, 273; mean = 4.03, SD = 1.034), healthcare providers' engagement with peer networks to provide accurate information (85.9%, 281; mean = 4.10, SD = 0.830), and the effect of peer pressure and social norms on individual choices (82.8%, 271; mean = 4.04, SD = 0.950). Agreement was comparatively lower regarding the role of peer networks and online communities in providing support and information, with 57.2% (187) agreeing or strongly agreeing (mean = 3.29, SD = 1.281), suggesting more mixed perceptions in this area.

Table 4. 8: Opinions of respondents on Health worker experience

Health worker experience	**Percentage Response (%)**						
	SD	**D**	**N**	**A**	**SA**	**Mean**	**Std dev**
Healthcare workers face challenges in providing support and care for individuals who have self-induced abortion	4.9% (16)	8.3% (27)	7.0% (23)	53.8% (176)	26.0% (85)	3.88	1.044
Healthcare workers address the needs of individuals seeking care after self-induced abortion	14.4% (47)	13.8% (45)	6.7% (22)	46.5% (152)	18.7% (61)	3.41	1.326
Healthcare workers ensure confidentiality and privacy for	3.7% (12)	10.7% (35)	6.7% (22)	50.5% (165)	28.4% (93)	3.89	1.050

individuals disclosing self-induced abortion experiences							
There are barriers that healthcare workers face in providing non-judgmental and compassionate care to individuals who have self-induced abortion	13.1% (43)	13.8% (45)	5.8% (19)	46.2% (151)	21.1% (69)	3.48	1.320
Healthcare policies and practices should be improved to enhance the quality of care for individuals who have self-induced abortion	2.8% (9	5.8% (19)	5.8% (19)	55.0% (180)	30.6% (100)	4.05	.919

Source: *Field data, 2025*

Table 4.8 indicates generally high agreement regarding healthcare workers' experiences and systemic issues in providing care for individuals who have self-induced abortion, with mean scores ranging from 3.41 to 4.05. The strongest agreement was that healthcare policies and practices should be improved to enhance quality of care, with 85.6% (280) agreeing or strongly agreeing (mean = 4.05, SD = 0.919). High agreement was also observed that healthcare workers face challenges in providing support and care (79.8%, 261; mean = 3.88, SD = 1.044) and that confidentiality and privacy are ensured for individuals disclosing self-induced abortion experiences (78.9%, 258; mean = 3.89, SD = 1.050). Agreement was moderately high regarding barriers to providing non-judgmental and compassionate care (67.3%, 220; mean = 3.48, SD = 1.320) and healthcare workers' ability to address post–self-induced abortion care needs (65.2%, 213; mean = 3.41, SD = 1.326), suggesting some variability and ongoing challenges in practice.

4.3 Correlations analysis

The correlation table illustrates a complex network of relationships among significant factors influencing reproductive health decisions. The researcher conducted a bivariate Pearson correlation analysis to establish the relationship between the variables under study, as summarized in Table 4.2 below. Correlation analysis helps to establish the strength of the relationship between the variables under study. This analysis was important in addressing the study objectives.

4.3.1 The behavioral factors associated with Self-induced Abortions among women of reproductive age (15-49) years

Table 4.9 below Shows correlation analysis results

	1	2	3	4	5	6	7	8	9
Parental consent	1								
Legal Restrictions	0.037	1							
Peer Influence	.586**	0.059	1						
Health worker experience	-0.049	.596**	0.081	1					
Self- Managed Abortion	**.601****	**.667****	**.663****	**.641****	**1**				
Induced Abortion Services	.154**	-0.022	.185**	-0.004	.120*	1			
Surgical Abortion	.187**	0.083	.366**	.333**	.376**	.113*	1		
Miscarriages	0.026	.590**	.129*	.899**	.646**	0.063	.339**	1	
AWRA	**.181****	**.329****	**.336****	**.615****	**.570****	**.593****	**.711****	**.703****	**1**

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Source: *Primary data (2024)*

The results in Table 4.9 above reveal a weak positive relationship between self-induced abortion and women of reproductive age of 15-49 years. The correlation is significant at the 0.01 level. This means that as the number of women of reproductive age of 15-49years increases, so does the prevalence of self-induced abortion. There is a weak but significant influence of parental consent on abortions among women of childbearing age ($r = 0.181^{**}$, $p < 0.01$). This explains 18.1% of

parental consent on abortion among women of childbearing age 15-49years. These are all significant at the 0.01 level including induced abortion services ($r = 0.154^{**}$, $p < 0.01$) and surgical abortion ($r = 0.187^{**}$, $p < 0.01$). Parental consent correlates with increased access to both induced abortion services and surgical abortions. These explain 15.4 and 18.7 percent of parental consent on abortion among women of childbearing age 15-49years respectively. The weak positive correlation suggests that higher parental consent may be associated with better induced abortion services. However, there is no correlation between parental consent and miscarriages. The p-value is insignificant at ($r = 0.026$). This means that parental consent explains only 2.6% of the miscarriages among women of reproductive age of 15-49years.

There is a moderately positive correlation between legal restrictions and abortions among women of reproductive age. The matrix also reveals that the p-value is significant at the 0.01 level ($r = 0.329^{**}$, $p < 0.01$). It explains 32.9% of abortions among women of reproductive age. This indicates that legal restrictions significantly influence abortions among women of reproductive age 15-49 years. There is also a negative correlation coefficient between legal restrictions and induced abortion services (-0.022). The p-value is insignificant, this shows that legal restrictions do not significantly impact self-induced abortion services. This suggests that as legal restrictions increase, self-induced abortion services do not significantly change, implying that legal restrictions may not be a major barrier to these services in this context. There is a weak positive influence between legal restrictions and surgical abortion ($r = 0.083$), and there is a strong, significant positive influence between legal restrictions and miscarriages ($r = 0.590^{**}$, $p < 0.01$). This strong positive influence suggests that higher legal restrictions are associated with an increase in reported miscarriages. This could imply that restrictive legal environments may lead to higher rates of

unintended pregnancies or unsafe abortion practices, potentially contributing to an increase in miscarriage rates.

The findings also indicate that there is a weak positive connection between peer influence and abortions among women of reproductive age ($r = 0.336^{**}$, $p<0.01$). This explains only 33.6% of peer influence on abortions among women of reproductive age. The p-value is significant at 0.01 which shows that peer influence significantly affects abortions among women of reproductive age 15-49 years. There is also a weak positive connection between peer influence and induced abortion services ($r = 0.185^{**}$, $p<0.01$) and this explains only 18.5% of peer influence on induced abortion services. The p-value is significant at 0.01 level. The positive significant correlation means that peer influence positively affects induced abortion services.

There is also a moderately significant positive relationship between peer influence and surgical abortion ($r = 0.366^{**}$, $p <0.01$). The p-value is significant at 0.01 level and this explains only 36.6% of peer influence on surgical abortion. This means that as peer influence increases, there is a corresponding increase in the likelihood of adolescents opting for surgical abortion. There is a weak positive relationship between peer influence and miscarriages ($r = 0.129^{*}$, $p<0.05$). This explains only 12.9% of peer influence on miscarriages. This means that there is a mild relationship between peer influence and the incidence of miscarriages among adolescents.

The correlation between health worker experience and induced abortion services shows a coefficient of (-0.004), indicating a negligible negative relationship. This suggests that there is virtually no correlation between the experience of health workers and the use of induced abortion services among adolescents. A moderate positive significant relationship between health worker experience and surgical abortion ($r = 0.333^{**}$, $p<0.01$). The moderate positive correlation indicates that greater health worker experience is associated with an increased likelihood of adolescents

opting for surgical abortion. This suggests that experienced health workers may provide better counseling, support, and procedural care, making adolescents more comfortable with the decision. There is a strong positive correlation between health worker experience and miscarriage (r =0.899**, p<0.01). There is also a moderately strong positive significant relationship between health worker experience and abortions among women of reproductive age (r =0.615**, p<0.01). The moderate positive correlation indicates that as health worker experience increases, so does the level of abortions among women of reproductive age. This suggests that experienced health workers may empower adolescents to make informed decisions about their reproductive health. The experience of health workers profoundly shapes different facets of teenage reproductive health care.

The correlation matrix results reveal significant association patterns, providing a complete understanding of these associations. The findings in Table 4.2 demonstrate a moderately strong statistically significant positive influence between self-induced abortion and abortions among women of reproductive age (r =0.615**, p<0.01). This implies that a unit improvement in self-induced abortion will lead to a unit improvement in the abortions among women of reproductive age in Jinja City. The obtained result exhibits statistical significance, as indicated by a p-value of 0.01 at the 0.01 level.

4.6. Empirical findings

On a 5-point Likert scale, respondents' opinions were scored as follows: 1. Strongly disagree (SD) 2. Disagree (D) 3. Not sure (NS) 4. Agree (A) 5. Strongly agree (SA)These results are shown below in accordance with the study's goals:

4.6.1 Socio-demographic factors associated with self-induced Abortions among women of reproductive age (15-49) years.

Table 4. 10: Opinions of respondents on age

Age	Percentage Response (%)						
	SD	**D**	**N**	**A**	**SA**	**Mean**	**Std dev**
There are barriers faced by younger women (15-24 years) in accessing safe and legal abortion services	2.1% (7)	4.6% (15)	5.5% (18)	49.8% (163)	37.9% (124)	4.17	.886
Age affect the availability of support networks and resources for women seeking abortions	14.4% (47)	13.1% (43)	11.9% (39)	42.8% (140)	17.7% (58)	3.36	1.310
Age influence the timing and gestational age at which women seek abortion services	1.8% (6)	8.9% (29)	8.0% (26)	45.9% (150)	35.5% (116)	4.04	.977
There are age-related stigma and discrimination on the access to abortion services	2.8% (9)	3.1% (10)	4.9% (16)	59.0% (193)	30.3% (99)	4.11	.844
There are differences in self-induced abortion services based on age across urban and rural areas	1.8% (6)	5.2% (17)	9.2% (30)	49.2% (161)	34.6% (113)	4.09	.897

Source: *Field data, 2025*

Table 4.10 indicates generally high agreement that age significantly influences access to abortion services, with mean scores ranging from 3.36 to 4.17. The strongest agreement was that younger women (15–24 years) face barriers in accessing safe and legal abortion services, with 87.7% (287) agreeing or strongly agreeing (mean = 4.17, SD = 0.886). High agreement was also observed regarding age-related stigma and discrimination (89.3%, 292; mean = 4.11, SD = 0.844), differences in access across urban and rural areas by age (83.8%, 274; mean = 4.09, SD = 0.897), and the influence of age on the timing and gestational age at which women seek abortion services (81.4%, 266; mean = 4.04, SD = 0.977). Agreement was comparatively lower on the effect of age

on the availability of support networks and resources, with 60.5% (198) agreeing or strongly agreeing (mean = 3.36, SD = 1.310), suggesting more varied perceptions in this area.

Table 4. 11: Opinions of respondents on marital status

Marital status	Percentage Response (%)						
	SD	**D**	**N**	**A**	**SA**	**Mean**	**Std dev**
Marital status influences the decision-making process and access to abortions among women of reproductive age (15-49 years)	4.9% (16)	5.8% (19)	8.0% (26)	58.1% (190)	23.2% (76)	3.89	.988
There is equitable access to abortion services regardless of marital status among women of reproductive age	14.7% (48)	15.6% (51)	4.3% (14)	45.6% (149)	19.9% (65)	3.40	1.355
Marital status impact the availability of support systems and resources for women seeking abortions	4.6% (15)	9.2% (30)	5.2% (17)	53.8% (176)	27.2% (89)	3.90	1.047
There are barriers faced by unmarried or divorced women in accessing safe and legal abortion services	11.9% (39)	16.8% (55)	7.3% (24)	41.6% (136)	22.3% (73)	3.46	1.324
Spousal consent plays a lot in the access to abortions for married women.	3.7% (12)	2.4% (8)	6.1% (20)	59.3% (194)	28.4% (93)	4.06	.879

Source: *Field data, 2025*

Table 4.11 indicates generally high agreement that marital status influences women's access to and experiences with abortion services, with mean scores ranging from 3.40 to 4.06. The strongest agreement was that spousal consent plays a significant role in access to abortion for married women, with 87.7% (287) agreeing or strongly agreeing (mean = 4.06, SD = 0.879). High agreement was also observed regarding the impact of marital status on support systems and resources for women seeking abortions (81.0%, 265; mean = 3.90, SD = 1.047) and its influence on decision-making and access to abortion (81.3%, 266; mean = 3.89, SD = 0.988). Agreement

was slightly lower on the presence of barriers faced by unmarried or divorced women (63.9%, 209; mean = 3.46, SD = 1.324) and on equitable access to abortion services regardless of marital status (65.5%, 214; mean = 3.40, SD = 1.355), suggesting more mixed perceptions in these areas.

Table 4. 12: Opinions of respondents on Place of residence

Place of residence	Percentage Response (%)						
	SD	**D**	**N**	**A**	**SA**	**Mean**	**Std dev**
The place of residence (urban, rural, etc.) impact access to abortion services for women of reproductive age (15-49 years)?	2.1% (7)	5.2% (17)	6.4% (21)	48.0% (157)	38.2% (125)	4.15	.909
Living in rural areas affect the availability of abortion clinics and healthcare facilities for women seeking abortions	14.4% (47)	10.4% (34)	16.5% (54)	40.4% (132)	18.3% (60)	3.38	1.295
Women in rural areas face challenges of transportation and logistics in accessing abortion services	2.1% (7)	5.8% (19)	8.0% (26)	47.4% (155)	36.7% (120)	4.11	.929
Social norms in different places impact access to abortion services for women of reproductive age	1.5% (5)	4.3% (14)	6.1% (20)	53.8% (176)	34.3% (112)	4.15	.832
Telemedicine and digital health solutions bridge the gap in access to abortion services between urban and rural areas	2.4% (8)	3.7% (12)	7.0% (23)	54.1% (177)	32.7% (107)	4.11	.869

Source: *Field data, 2025*

Table 4.12 indicates generally high agreement that place of residence influences access to abortion services for women of reproductive age, with mean scores ranging from 3.38 to 4.15. The strongest agreement was that social norms in different places impact access to abortion services, with 88.1% (288) agreeing or strongly agreeing (mean = 4.15, SD = 0.832), followed closely by perceptions that place of residence broadly affects access (86.2%, 282; mean = 4.15, SD = 0.909) and that

telemedicine can bridge urban–rural gaps (86.8%, 284; mean = 4.11, SD = 0.869). High agreement was also observed regarding transportation and logistical challenges faced by rural women (84.1%, 275; mean = 4.11, SD = 0.929). Agreement was comparatively lower on the availability of abortion clinics and healthcare facilities in rural areas, with 58.7% (192) agreeing or strongly agreeing (mean = 3.38, SD = 1.295), suggesting more varied perceptions on service availability.

Table 4. 13: Opinions of respondents on employment

Employment	Percentage Response (%)						
	SD	**D**	**N**	**A**	**SA**	**Mean**	**Std dev**
Unemployed or underemployed women face barriers in accessing abortion services	2.8% (9)	5.8% (19)	7.3% (24)	53.2% (174)	30.9% (101)	4.04	.929
Working hours and scheduling constraints affect the ability of women to seek abortion services	14.4% (47)	12.2% (40)	10.1% (33)	42.8% (140)	20.5% (67)	3.43	1.329
Employment status influence the ability self-induced abortion services for women of reproductive age (15-49 years)	4.0% (13)	7.6% (25)	8.9% (29)	50.5% (165)	29.1% (95)	3.93	1.020
Job stability and benefits impact the decision-making process of women seeking abortions	11.6% (38)	13.8% (45)	10.1% (33)	44.6% (146)	19.9% (65)	3.47	1.274
Workplace accommodations and support programs improve self-induced abortion services for employed women	4.9% (16)	5.2% (17)	5.5% (18)	49.5% (162)	34.9% (114)	4.04	1.026

Source: *Field data, 2025*

Table 4.13 indicates generally high agreement that employment-related factors influence women's access to abortion services, with mean scores ranging from 3.43 to 4.04. The strongest agreement was that workplace accommodations and support programs improve access to abortion services

for employed women, with 84.4% (276) agreeing or strongly agreeing (mean = 4.04, SD = 1.026), closely followed by the view that unemployed or underemployed women face barriers to accessing abortion services (84.1%, 275; mean = 4.04, SD = 0.929). High agreement was also observed that employment status influences self-induced abortion services (79.6%, 260; mean = 3.93, SD = 1.020). Agreement was comparatively lower regarding the effects of working hours and scheduling constraints (63.3%, 207; mean = 3.43, SD = 1.329) and job stability and benefits on abortion decision-making (64.5%, 211; mean = 3.47, SD = 1.274), suggesting more mixed perceptions in these areas.

4.3.2 The socio-demographic factors associated with self-induced abortion among women of reproductive age (15-49) years in Jinja Regional Referral Hospital

Table 4.14 below Shows correlation analysis results

	1	2	3	4	5	6	7	8	9
Age	1								
Marital status	.296**	1							
Place of residence	.644**	0.098	1						
Employment	0.086	0.024	.134*	1					
Socio-Demographic									
Factors	**.786****	**.558****	**.726****	**.492****	**1**				
Induced Abortion									
Services	.151**	0.107	.133*	.489**	.347**	1			
Surgical Abortion	.525**	.306**	.237**	-0.004	.414**	.113*	1		
Miscarriages	.345**	.863**	.121*	0.019	.530**	0.063	.339**	1	
AWRA	**.505****	**.640****	**.244****	**.256****	**.644****	**.593****	**.711****	**.703****	**1**

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Source: *Primary data (2024)*

The results from the Table 4.14 shows that there is a strong positive relationship (r =0.644**, p<0.01) between socio-demographic factors and abortions among women in Jinja City who are 15 to 49 years old and of childbearing age. The p-value is significant at 0.01 level. This means that as age increases, access to women's reproductive health services also tends to increase significantly. This implies a higher likelihood of older individuals seeking abortion services. The results of the correlation matrix also demonstrate a weak positive significant link between age and induced abortion services (r =0.154**, p<0.01) and surgical abortion (r =0.187**, p<0.01). This implies that factors like availability, personal circumstances, increased awareness, and acceptance may influence the likelihood of older individuals seeking surgical abortion services. The matrix also reveals that there is an insignificant relationship between age and miscarriages (r =0.026). This implies that there is no substantial relationship between a person's age and the occurrence of miscarriages, indicating that age may not be a determining factor in miscarriage rates. There is also a very strong positive significant influence between age and abortion among women of reproductive age of 15-49 years (r =0.505**, p<0.01). This implies that older people are more likely to pursue these services.

The correlation matrix also demonstrates a positive, insignificant influence between marital status and self-induced abortion services (r =.107), a moderately strong and significant relationship between marital status and surgical abortion (r =0.306**, p<0.01), and a very strong and positive influence between marital status and miscarriages (r =0.863**, p<0.01). There is also a strong and positive significant influence between marital status and abortion among women of reproductive age 15-49 years (r =0.640**, p<0.01). This indicates that married individuals have better access to women's reproductive health services. This could be due to various factors, including social support systems, financial stability, and increased awareness of available services.

The correlation matrix also shows a weak positive and significant relationship between where a woman of reproductive age lives and having an abortion ($r = 0.244^{**}$, $p<0.01$), an induced abortion ($r = 0.133^{*}$, $p<0.05$), a surgical abortion ($r = 0.237^{**}$, $p<0.01$), and a miscarriage ($r = 0.121^{*}$, $p<0.05$). This suggests that women who live in areas with better access to healthcare are more likely to use surgical abortion services. This suggests that the incidence of miscarriages is not significantly influenced by the place of residence, suggesting that factors other than location may have a greater influence.

The correlation matrix also reveals that there is a weak positive relationship ($r = 0.113^{*}$, $p<0.05$) between employment and induced abortion services. This suggests that employment may be associated with induced abortion services, but not strongly. This suggests that employment alone may not significantly influence the decision to seek abortion services. A strong positive significant relationship between employment and surgical abortion ($r = 0.499^{**}$, $p<0.01$), suggesting that women who are employed are more likely to access surgical abortion services. Employment may provide financial resources and insurance coverage that facilitate self-induced abortion these services. The correlation matrix also indicates a weak yet statistically significant relationship between employment and miscarriages ($r = 0.204^{*}$, $p<0.05$). This suggests that employed women might experience slightly higher rates of reported miscarriages.

4.7 Empirical findings

On a 5-point Likert scale, respondents' opinions were scored as follows: 1. Strongly disagree (SD) 2. Disagree (D) 3. Not sure (NS) 4. Agree (A) 5. Strongly agree (SA)These results are shown below in accordance with the study's goals:

4.7.1 Reproductive health behavioral factors associated with self-induced Abortions among women of reproductive age (15-49) years.

Table 4. 15: Opinions of respondents on multiple sex partners

Multiple Sex Partners	Percentage Response (%)						
	SD	D	N	A	SA	Mean	Std dev
I have ever had multiple sex partners	2.1% (7)	3.7% (12)	5.5% (18)	51.4% (168)	37.3% (122)	4.18	.859
Multiple sex partners influence reproductive health behaviors and access to abortion services for women of reproductive age (15-49 years)	16.2% (53)	12.8% (42)	15.3% (50)	39.4% (129)	16.2% (53)	3.27	1.324
Communication and negotiation with multiple sex partners impact contraceptive use and access to abortion services	0.9% (3)	4.0% (13)	8.6% (28)	43.7% (143)	42.8% (140)	4.24	.838
Awareness about sexually transmitted infections play in the decision-making process of women with multiple sex partners seeking abortions	1.2% (4)	2.1% (7)	8.6% (28)	57.5% (188)	30.6% (100)	4.14	.754
Healthcare providers address the unique needs and concerns of women with multiple sex partners seeking abortion services	1.2% (4)	4.6% (15)	8.9% (29)	51.4% (168)	33.9% (111)	4.12	.842

Source: Field data, 2025

Table 4.15 indicates generally high agreement regarding the relationship between multiple sex partners and reproductive health behaviors and access to abortion services, with mean scores ranging from 3.27 to 4.24. The strongest agreement was on the influence of communication and negotiation with multiple sex partners on contraceptive use and access to abortion services, with 86.5% (283) agreeing or strongly agreeing (mean = 4.24, SD = 0.838). High agreement was also observed for awareness of sexually transmitted infections in abortion decision-making among

women with multiple sex partners (88.1%, 288; mean = 4.14, SD = 0.754), healthcare providers addressing the unique needs of these women (85.3%, 279; mean = 4.12, SD = 0.842), and respondents' personal experience of having multiple sex partners (88.7%, 290; mean = 4.18, SD = 0.859). Agreement was comparatively lower on the influence of multiple sex partners on reproductive health behaviors and access to abortion services, with 55.6% (182) agreeing or strongly agreeing (mean = 3.27, SD = 1.324), suggesting more varied perceptions on this issue.

Table 4. 16: Opinions of respondents on multiple sex partners

Non-Consensual Sex	Percentage Response (%)						
	SD	**D**	**N**	**A**	**SA**	**Mean**	**Std dev**
Non-consensual sex impact reproductive health behaviors and access to abortion services	3.7% (12)	4.9% (16)	7.0% (23)	56.3% (184)	28.1% (92)	4.00	.938
Trauma from non-consensual sex influence the ability of women to seek and access abortion services	16.2% (53)	13.5% (44)	5.5% (18)	44.3% (145)	20.5% (67)	3.39	1.377
Survivors of non-consensual sex face difficulties in disclosing their experiences and seeking abortion care	2.8% (9)	8.3% (27)	5.8% (19)	55.0% (180)	28.1% (92)	3.98	.959
Healthcare providers provide trauma-informed care to women who have experienced non-consensual sex and are seeking abortions	12.8% (42)	14.7% (48)	4.9% (16)	45.3% (148)	22.3% (73)	3.50	1.329
Victim-blaming impact access to abortion services for survivors of non-consensual sex	4.0% (13)	3.1% (10)	6.1% (20)	55.4% (181)	31.5% (103)	4.07	.924

Source: *Field data, 2025*

Table 4.16 indicates generally high agreement on the effects of non-consensual sex on access to abortion services, with mean scores ranging from 3.39 to 4.07. The strongest agreement was that

victim-blaming impacts access to abortion services for survivors, with 86.9% (284) agreeing or strongly agreeing (mean = 4.07, SD = 0.924). High agreement was also observed regarding the impact of non-consensual sex on reproductive health behaviors and access to abortion (84.4%, 276; mean = 4.00, SD = 0.938) and the difficulties survivors face in disclosing experiences and seeking abortion care (83.1%, 272; mean = 3.98, SD = 0.959). Agreement was comparatively lower on whether trauma influences women's ability to seek and access abortion services (64.8%, 212; mean = 3.39, SD = 1.377) and on the provision of trauma-informed care by healthcare providers (67.6%, 221; mean = 3.50, SD = 1.329), suggesting greater variability in perceptions of trauma-related barriers and provider practices.

Table 4. 17: Opinions of respondents on access to contraception

Access to Contraception	Percentage Response (%)						
	SD	**D**	**N**	**A**	**SA**	**Mean**	**Std dev**
Barriers to accessing contraception lead women to seek abortions instead	2.4% (8)	3.7% (12)	3.1% (10)	50.5% (165)	40.4% (132)	4.23	.867
The availability of different contraceptive methods impacts the decision-making process of women regarding abortion services	14.7% (48)	11.9% (39)	14.1% (46)	39.8% (130)	19.6% (64)	3.38	1.323
Awareness about contraception play a role in preventing the need for abortions among women of reproductive age	0.9% (3)	5.8% (19)	7.6% (25)	46.8% (153)	38.8% (127)	4.17	.868
Healthcare providers promote and facilitate access to effective contraception	2.1% (7)	2.4% (8)	4.9% (16)	58.1% (190)	32.4% (106)	4.16	.800
Interventions are needed to improve access to a wide range of contraceptive options	1.8% (6)	4.0% (13)	6.4% (21)	51.4% (168)	36.4% (119)	4.17	.853

Source: *Field data, 2025*

Table 4.17 indicates generally high agreement regarding access to contraception and its role in preventing abortions, with mean scores ranging from 3.38 to 4.23. The strongest agreement was that barriers to accessing contraception lead women to seek abortions instead, with 90.9% (297) agreeing or strongly agreeing (mean = 4.23, SD = 0.867). High agreement was also observed for the role of awareness about contraception in preventing the need for abortions (85.6%, 280; mean = 4.17, SD = 0.868), the need for interventions to improve access to a wide range of contraceptive options (87.8%, 287; mean = 4.17, SD = 0.853), and healthcare providers' promotion of effective contraception (90.5%, 296; mean = 4.16, SD = 0.800). Agreement was comparatively lower on the impact of the availability of different contraceptive methods on decision-making regarding abortion services, with 59.4% (194) agreeing or strongly agreeing (mean = 3.38, SD = 1.323), indicating more variability in perceptions.

Table 4. 18: Opinions of respondents on Unsafe Sex Practices

Unsafe Sex Practices	Percentage Response (%)						
	SD	**D**	**N**	**A**	**SA**	**Mean**	**Std dev**
There are risks associated with unsafe sex practices in terms of unintended pregnancies and the need for abortions	3.4% (11)	4.9% (16)	6.1% (20)	56.6% (185)	29.1% (95)	4.03	.923
Lack of access to sex education contribute to unsafe sex practices and abortion	15.0% (49)	12.8% (42)	8.6% (28)	44.0% (144)	19.6% (64)	3.40	1.339
Limited access to contraception and preventive measures increased the prevalence of unsafe sex practices and abortions	4.3% (14)	8.3% (27)	4.9% (16)	50.2% (164)	32.4% (106)	3.98	1.045
Unsafe sex practices impact reproductive health behaviors and the likelihood of seeking abortions	13.5% (44)	16.2% (53)	5.8% (19)	41.3% (135)	23.2% (76)	3.45	1.360

Education and empowerment of women reduce the risk of unintended pregnancies	2.1% (7)	3.4% (11)	4.9% (16)	58.4% (191)	31.2% (102)	4.13	.820

Source: *Field data, 2025*

Table 4.18 indicates generally high agreement regarding the risks and contributing factors of unsafe sex practices, with mean scores ranging from 3.40 to 4.13. The strongest agreement was that education and empowerment of women reduce the risk of unintended pregnancies, with 89.6% (293) agreeing or strongly agreeing (mean = 4.13, SD = 0.820). High agreement was also observed for the risks associated with unsafe sex practices in terms of unintended pregnancies and the need for abortions (85.7%, 280; mean = 4.03, SD = 0.923) and for limited access to contraception and preventive measures increasing unsafe sex and abortion prevalence (82.6%, 270; mean = 3.98, SD = 1.045). Agreement was comparatively lower regarding lack of access to sex education contributing to unsafe sex practices and abortion (63.6%, 208; mean = 3.40, SD = 1.339) and the impact of unsafe sex practices on reproductive health behaviors and likelihood of seeking abortions (64.5%, 211; mean = 3.45, SD = 1.360), suggesting greater variability in perceptions of educational and behavioral influences.

4.3.3 The reproductive health behavioral factors associated with self-induced Abortions among women of reproductive age of (15-49) years

Table 4.19 below Shows correlation analysis results

	1	2	3	4	5	6	7	8	9
Multiple Sex Partners	1								
Non-Consensual Sex	.285**	1							
Self-induced abortion									
Contraception	.362**	.251**	1						
Unsafe Sex Practices	.132*	.651**	0.046	1					
Reproductive Health Behaviors	**.644****	**.812****	**.592****	**.681****	**1**				

Induced Abortion Services	.113*	-0.019	0.072	-0.032	0.047	1			
Surgical Abortion	.499**	0.082	.250**	0.034	.311**	.113*	1		
Miscarriages	.204**	.523**	.133*	.503**	.505**	0.063	.339**	1	
AWRA	**.401****	**.295****	**.224****	**.255****	**.430****	**.593****	**.711****	**.703****	**1**

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Source: *Primary data (2024)*

The correlation matrix in Table 4.19 above reveals varying degrees of relationships between Multiple Sex Partners and reproductive health outcomes, indicating a complex landscape. The weak positive correlation with induced abortion services ($r = 0.113^*$, $p<0.05$) suggests a slight inclination towards increased use of these services among those with multiple partners, though this relationship is not strong. In addition, there is a moderate correlation with surgical abortion ($r = 0.499^{**}$, $p<0.01$). This indicates a significant tendency for individuals with multiple partners to seek surgical abortions, suggesting a greater risk of unplanned pregnancies or varying reproductive health behaviors. Similarly, there is a weak but significant correlation with miscarriages ($r = 0.204^{**}$, $p<0.01$). This implies potential reproductive complications. There is also a moderate influence with abortion among women of reproductive age ($r = 0.401^{**}$, $p<0.01$), suggesting that having multiple sexual partners may lead to higher abortion rates.

The correlation matrix indicates a complex relationship between nonconsensual sex and the various reproductive health outcomes. The near-zero correlation with induced abortion services (-0.019) suggests a negligible relationship, indicating that non-consensual sex does not significantly impact the use of these services. However, a weak correlation ($r = .082$) indicates a slight positive relationship, implying that people who engage in non-consensual sex might have a slightly higher chance of undergoing surgical abortions, despite the lack of strong evidence to support this. There is a strong, significant correlation with miscarriages ($r = 0.523^{**}$, $p < 0.01$). The data suggests that

individuals who have engaged in non-consensual sex might be more susceptible to miscarriages, possibly as a result of trauma or health issues. Additionally, there is a moderate correlation with abortion among women of reproductive age ($r = 0.295^{**}$, $p < 0.01$), reflecting that non-consensual sex may be linked to a higher prevalence of abortions within this demographic. These findings suggest that while the association with abortion services may be weak, the significant correlations with miscarriages and abortion highlight the urgent need for supportive healthcare services and interventions for individuals affected by non-consensual sexual experiences to address their reproductive health needs.

The correlation matrix reveals moderate and weak relationships between "Access to Contraception" and various reproductive health outcomes, suggesting key implications for reproductive health management. There is a weak positive correlation with induced abortion services ($r = 0.072$). This indicates that access to contraception has little impact on the use of these services, suggesting potential gaps in contraceptive effectiveness or utilization. There is also a moderately positive and significant correlation with surgical abortion ($r = 0.250^{**}$, $p < 0.01$). This implies a potential link between enhanced access to contraception and a decreased risk of surgical abortions, suggesting that improved access to contraception could aid in preventing unintended pregnancies. Additionally, there is a weak correlation with miscarriages ($r = 0.133^{*}$, $p < 0.05$) and a moderate correlation with abortion among women of reproductive age ($r = 0.224^{**}$, $p < 0.01$). This indicates that while there is a slight association between access to contraception and these outcomes, the influence is not particularly strong.

The correlation matrix highlights important relationships between unsafe sex practices and various reproductive health outcomes, indicating significant implications for health interventions. There are negligible negative correlations with induced abortion services (-0.032) and surgical abortion

(r =0.034). This suggests that unsafe sex practices do not directly influence the use of these abortion services, indicating a low likelihood of immediate impact. There is also a strong positive correlation with miscarriages (r =0.503**, p <0.01). This implies that unsafe sex practices may significantly increase the risk of miscarriages, reflecting potential complications arising from health risks associated with such practices. Additionally, there is a moderate correlation with abortion among women of reproductive age (r =0.255**, p<0.01). This suggests a link between unsafe sex practices and higher abortion rates within this demographic, potentially due to an increase in unintended pregnancies.

4.4 The joint influence of the factors associated with self-induced abortion among women of reproductive age (15-49) years

4.4.1 Regression Analysis

The linear regression model was used to examine the predictive power of the factors associated with self-induced abortion among women of (15-49) years. The regression analysis's results explained the predictive power of self-induced abortion, socio-demographic factors, and reproductive health behavior on abortions among women of reproductive age of (15-49) years, resulting from changes in these factors, using the Pearson coefficient of determination (r 2). The researcher then combined the results from the data collection tools with the linear regression analysis. The table below presents the results.

Table 4.20 Showing regression analysis results

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Collinearity Statistics	
		B	Std. Error	Beta			Tolerance	VIF
1	(Constant)	0.606	0.201		3.011	0.003		
	Self-induced Abortion	0.15	0.068	0.141	2.202	0.028	0.411	2.434

	Socio-Demographic Factors	0.51	0.066	0.473	7.729	0.001	0.453	2.209
	Reproductive Health Behaviors	0.159	0.049	0.157	3.276	0.001	0.738	1.355
	R Square	0.453						
	Adjusted R Square	0.448						
	R Square Change	0.453						
	F Change	89.033						
	Sig. F Change	0.001						

a Dependent Variable: Abortion among Women of Reproductive Age

Source: *Primary data (2024)*

The linear regression model (Table 4.20 above) shows that the factors such as self-induced abortion, socio-demographic factors, and reproductive health behavior together explain (44.8%) of the variation in how well abortions among women of reproductive age of 15-49 years' work (adjusted R^2 =.448). This implies that there are other factors that explain the remaining (55.2%) of the variance in the abortions among women of reproductive age of (15-49) years. The adjusted R square gives an idea of how well the regression model generalizes the study variables, and ideally, every researcher would like its value to be the same or very close to the value of the R square. However, Ajjaj, El Houssaini, Hain, and El Houssaini (2022) used the adjusted R square as a better goodness-of-fit measure.

Findings in Table 4.20 also showed that self-induced abortion, socio-demographic factors, and reproductive health behavior contributed to the abortions among women of reproductive age (R squared = 0.453). The beta and F change ($F = 89.033$, $p<.01$) were positive, implying that self-induced abortion, socio-demographic factors, and reproductive health behavior positively predicted abortions among women of reproductive age of 15-49 years. The results further confirmed that self-induced abortion, socio-demographic factors, and reproductive health behavior are significant predictors of the self-induced abortions among women of reproductive age of 15-49 years at the 1% significance level.

Additionally, the regression analysis results (Table 4.20 above) showed that the predictor variables explain at least (44.8%) of the variance in the self-induced abortion among women of reproductive age of 15-49 years (adjusted R square =.453). The results further revealed that socio-demographic factors, (Beta =.473, Sig. = 0.00) was the strongest predictor, followed by reproductive health behavior, which is significant (Beta =.157, Sig. 0.00), and self-induced abortion (Beta=.141, Sig. 0.02), respectively. Meaning that a change in socio-demographic factors leads to (0.473) positive changes in the self-induced abortion among women of reproductive age of 15-49 years, while reproductive health behavior contributes (0.157) and self-induced abortion contributes (0.141) positive changes in the self-induced abortion among women of reproductive ages, 15-49 years respectively. The regression model was also observed to be significant (F = 89.033, Sig<.00) and could thus be used to reliably make recommendations and conclusions for the self-induced abortion among women of reproductive age of 15-49 years in Jinja City.

CHAPTER FIVE
DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter discusses the study's findings, conclusions, and recommendations for further research. The chapter draws conclusions from the research objectives and provides recommendations for improvement, as well as future studies. The objectives, therefore, guided the study:

5.2.1 The behavioural factors associated with Self-induced Abortions among reproductive aged women of (15-49) years.

The results indicate that self-induced abortion and reproductive health behaviours significantly influence the likelihood of abortion within this demographic. The findings highlight a significant relationship between self-induced abortion and reproductive health behaviours, indicating that women who engage in self-induced abortions are more likely to undergo abortions. This result aligns with existing literature that emphasises the increasing trend of self-induced abortions, particularly in contexts where there is limited safe and legal abortion services.

Several scholars have noted that self-induced abortion can be a response to barriers in accessing formal healthcare services. For instance, studies by (Ralph et al., 2020; Jayaweera et al., 2021; Almengual et al. 2024) have documented how women in restrictive environments often resort to self-induced methods due to a lack of available options. The findings contribute to this discourse by providing empirical evidence that reinforces the notion that self-induced abortion is not merely a choice but often a necessity driven by systemic barriers.

However, some scholars argue that self-induced abortion can empower women by giving them control over their reproductive choices (Yanow et al., 2021; Braine, 2023; Aiken et al., 2023), others caution against the potential health risks associated with unregulated methods (Staschus,

2023; Calkin, 2023). This divergence in perspectives highlights an ongoing academic debate regarding the safety and efficacy of self-induced abortions. The finding is in agreement with existing literature while also challenging certain assumptions about self-induced abortion. They underscore the importance of addressing the systemic barriers that force women to self-manage abortions and highlight a need for comprehensive reproductive health education and services. This dual perspective, suggests that while self-induced abortion can be seen as an act of agency, it also necessitates a critical approach to ensure women's health and safety in reproductive decision-making.

Furthermore, the findings regarding parental consent as a significant factor in accessing abortion services for younger women resonate with existing literature, particularly the work of Aiken et al., (2023). Their research underscores the challenges that parental involvement poses, suggesting that the requirement for consent can act as a barrier, deterring younger individuals from seeking necessary care. This aligns with broader discussions in the academic community about the socio-demographic factors influencing access to reproductive health services.

In the literature, there is a consensus that parental consent laws can disproportionately affect younger women, particularly those from marginalized backgrounds who may lack supportive family structures. For instance, Nathan et al., (2023) and Almengual et al., (2024) studies have shown that young women who feel they cannot discuss their reproductive choices with their parents are less likely to seek abortion services, which can lead to delayed care or unwanted pregnancies. This aligns with the study findings, which highlight the psychological and social pressures that parental consent can impose.

However, there is also a departure in the literature regarding the extent to which parental consent impacts decision-making. Some scholars, for instance Koiwa, Shishido, and Horiuchi (2024),

argue that while parental consent is a barrier, it is not the sole factor influencing a young woman's decision to seek an abortion. For example, factors such as socioeconomic status, access to information, and the availability of services also play critical roles. This perspective suggests that while parental consent is significant, it should be viewed within a broader context of intersecting influences. Moreover, some researchers, such as Baxter (2024) and Francis (2021), advocate for the removal of parental consent laws, arguing that they infringe on the autonomy of young women and can lead to negative health outcomes. Others contend that parental involvement can provide necessary support and guidance, emphasizing the need for a balanced approach that considers the diverse experiences of young women. The findings regarding parental consent as a critical factor in accessing abortion services for younger women align with the literature, particularly Aiken et al. (2023). However, the argument highlights the need to consider multiple factors that influence decision-making and access to care. This complexity calls for more or further research to explore the interplay of these factors so as to inform policies that support young women's reproductive health needs effectively.

5.2.2 The socio-demographic factors associated with self-induced abortion among women of reproductive age (15-49) years

The findings from your regression analysis highlight the significant role of socio-demographic factors particularly education level, income, and marital status in shaping women's self-induced abortion services. The strong relationship between these factors and the likelihood of accessing safe abortion services underscores the importance of socio-economic status in reproductive health decisions. This aligns with the work of Ouedraogo et al., (2024), who emphasize that socio-demographic characteristics such as age, education, and income are critical in shaping reproductive health behaviors. Furthermore, studies by Akhter, Dasvarma, and Saikia, (2020) support this

notion, indicating that women from different socio-economic backgrounds experience varying levels of access to reproductive health information and resources. This suggests a consensus in the literature regarding the influence of socio-demographic factors on abortion access, reinforcing the need for tailored interventions that address these disparities.

The research also reveals that age, marital status, education level, and socio-economic status significantly influence abortion practices. Younger women, particularly those aged 15-24, exhibit higher rates of seeking abortions compared to older women, a finding that resonates with the studies conducted by Sikaluzwe et al., (2024). These studies similarly highlight the vulnerabilities faced by younger women, including limited access to reproductive health education and services. Additionally, the observation that unmarried women are more likely to seek abortions than their married counterparts reflects the social stigma surrounding premarital pregnancies, a theme explored by Lai and Choi (2021) and Huang (2020). This alignment with existing literature underscores a shared understanding of the socio-cultural dynamics influencing abortion decisions among different demographic groups.

The analysis indicates that a significant portion of the variance in self-induced abortion is explained by the socio-demographic factors analyzed, reinforcing the model's robustness. This level of explanatory power is consistent with the findings of Mare et al., (2023) who also emphasize the importance of socio-demographic factors in understanding reproductive health outcomes. Their research highlights the relevance of statistical robustness in analyzing complex relationships, a point that this analysis further supports by demonstrating the absence of multicollinearity among predictors.

Marital status emerges as a critical factor in the analysis, with unmarried women more likely to seek abortions due to the social stigma associated with premarital pregnancies. This finding is

corroborated by Moore et al., (2021) and Oluseye, Waterhouse, and Hoggart, (2022), who note that unmarried women frequently encounter barriers in accessing reproductive health services. This also aligns with the work of Tomar, Pathak, and Bhakuni (2024), which discuss the social pressures and stigma that unmarried women face, complicating their decision-making processes regarding abortion. The implications of these findings underscore the need for supportive policies that address the unique challenges faced by unmarried women, a perspective that is often underrepresented in the literature. While many studies focus on the general trends in abortion access, this finding highlight the necessity of targeted interventions that consider the specific needs of unmarried women, contributing to a more in-depth understanding of reproductive health dynamics.

The place of residence significantly impacts women's experiences with abortion, with urban women generally having better access to healthcare facilities and information compared to their rural counterparts. This observation aligns with the work of Haksgaard (2020), which emphasizes disparities in access to reproductive health services based on geographic location. Additionally, research by Shewale and Sahay (2022) and Owoo (2024) highlights the challenges faced by rural women in accessing reproductive health services, reinforcing the necessity for targeted interventions to improve safe abortion services in rural areas. While existing literature acknowledges these disparities, this finding contributes to the academic debate by illustrating the specific barriers faced by rural women, such as geographical distance and cultural norms, which may not be as thoroughly explored in previous studies.

Furthermore, employment status emerges as a vital socio-demographic factor influencing abortion decisions. The regression analysis suggests that employed women are more likely to seek safe abortion services compared to their unemployed counterparts, a correlation supported by research

by Miller, Wherry, and Foster, (2023). This finding also aligns with studies by Gammage, Joshi, and Rodgers (2020), which emphasize the importance of economic factors in reproductive health decision-making. However, while existing literature often highlights the role of economic empowerment in enhancing access to healthcare services, this finding suggest that initiatives aimed at improving women's employment opportunities could have a more pronounced impact on reproductive health outcomes than previously recognized.

5.2.3 The reproductive health behavioral factors associated with self-induced Abortions among women of reproductive age (15-49) years

The regression analysis revealed critical insights into how these behaviors influence self-induced abortion services. The findings indicate that reproductive health behaviors, such as contraceptive use, frequency of health check-ups, and overall health literacy, significantly impact the ability of women to access safe abortion services. The analysis shows a notable unstandardized coefficient for reproductive health behaviors, suggesting a strong positive relationship between proactive reproductive health behaviors and the likelihood of accessing abortion services. This is in agreement with (Ajayi & Ezegbe, 2020; Mediawati, et al., 2022) who observed that women who engage in regular health practices and are knowledgeable about their reproductive health are more likely to seek and obtain safe abortion care.

Beginning with multiple sex partners, the analysis indicates that this behaviour is linked with an increase in the risk of unintended pregnancies, which can subsequently lead to higher rates of abortion. Women engaged in sexual relationships with multiple partners may face challenges in consistently using contraception and may greatly be exposed to sexually transmitted infections. Research by Adoma, (2024). supports this observation, highlighting that women with many sexual partners often experience a lack of control over their reproductive choices, which can result in

unintended pregnancies. This underscores the necessity for comprehensive sexual education programs that promote safe sexual practices and empowers women to make informed decisions regarding their reproductive health.

Non-consensual sex is another critical factor reflected in the regression analysis. The data suggests that women who have experienced non-consensual sexual encounters are at a significantly higher risk of unintended/unplanned pregnancies and subsequent abortions. This finding is particularly alarming, as it underscores the intersection of reproductive health and sexual violence. This aligns with the study of (Pun, et al., 2021; Ruschel, et al., 2022; Meier et al., 2021 and Crawford, et al., 2022) who observed that survivors of sexual violence often encounter barriers in accessing reproductive health services, including abortion. The trauma associated with non-consensual experiences can complicate decision-making and hinder women's ability to seek timely care. Addressing the issue of sexual violence and providing adequate support for survivors is essential for improving reproductive health outcomes and ensuring that women can access the care they need.

Access to contraception emerges as a pivotal factor influencing reproductive health behaviors and abortion rates. The regression analysis indicates that women with better access to contraceptive methods are less likely to experience unintended pregnancies, thereby reducing the likelihood of seeking abortions. This finding aligns with the work of (Wondie, 2021; Fatusi, et al., 2021; Ajayi & Ezegbe, 2020), who emphasized the importance of ensuring that women have access to a variety of contraceptive options and comprehensive reproductive health education. By improving access to contraception, healthcare providers can empower women’s ability to make informed choices regarding their reproductive health, ultimately decreasing the incidence of unplanned pregnancies and the need for abortion services.

Lastly, unsafe sex practices are a significant concern in the context of reproductive health behaviors. The regression analysis suggests that women who engage in unsafe sex practices, such as inconsistent condom use or lack of protection during sexual encounters, are at a higher risk of unintended pregnancies and STIs. This behaviour leads to increased rates of abortion, particularly among those who may not have access to safe and effective contraceptive methods. Research by (Okenyoru et al., 2024; and Seidu, et al., 2022) supports this finding, indicating that unsafe sex practices are prevalent among women who lack comprehensive sexual education and access to reproductive health services.

5.3 Conclusion

Three objectives guided the study: The research highlights the link between self-induced abortion and reproductive health behaviors, with women often resorting to such methods due to systemic barriers in accessing safe and legal abortion services.

(i) The regression analysis highlights the critical role of reproductive health behaviors in influencing access to safe abortion services. Key behaviors, such as contraceptive use, regular health check-ups, and health literacy, are strongly linked with the likelihood of accessing abortion care.

(ii) Comprehensive examination of systemic barriers and parental consent laws, as well as policies supporting reproductive health education and services. A revaluation of parental consent laws is necessary to reduce access barriers for younger individuals, particularly those from marginalized backgrounds.

(iii) Policymakers should address systemic barriers to safe abortion services and enhance comprehensive reproductive health education to empower women in making informed decisions.

(iv) Promoting open communication within families about reproductive health should be encouraged, alongside ongoing research to explore the complex factors influencing young women's abortion decisions.

(v) Additionally, factors like; multiple sexual partners and experiencing non-consensual sex significantly elevate the risk of unintended pregnancies, leading to higher abortion rates.

(vi) The findings underscore the importance of comprehensive sexual education programs, improved access to contraceptive methods, and robust support for survivors of sexual violence. Addressing these issues is essential for enhancing reproductive health outcomes and ensuring that women can make sound-informed choices regarding their reproductive health.

(vii) Socioeconomic status, access to information, and availability of services also play crucial roles in reproductive decision-making.

5.4 Recommendations.

Based on these findings, several recommendations were made to enhance self-induced abortion services for women of reproductive age in Jinja.

(i) **Enhance Comprehensive Reproductive Health Education**: Programs should be implemented to inform women about safe abortion practices, contraceptive options, and reproductive rights. This education should empower women to make sound informed decisions regarding their reproductive health

(ii) **Re-evaluate Parental Consent Laws**: A thorough review of parental consent laws should be conducted to assess their impact on young women's self-induced abortion services. Consideration should be given to modifying or removing these laws to reduce barriers for younger individuals, particularly those from marginalized backgrounds

(iii) **Address Systemic Barriers to Safe Abortion Services**: Policymakers should work to eliminate systemic barriers that limit access to safe and legal abortion services. This includes advocating for improved healthcare infrastructure and resources in restrictive environments to reduce the reliance on self-induced abortions.

(iv) **Support Open Communication in Families**: Initiatives should be developed to encourage open communication between young women and their families regarding reproductive health. This could involve community programs that educate families about reproductive rights and the importance of supportive environments.

(v) **Promote Safe Sexual Practices**: Public health campaigns should be launched to promote safe sexual practices, including consistent condom use and protection during sexual encounters. These campaigns should focus on increasing awareness levels of the risks associated with unsafe sex and the advantages of preventive measures.

(vi) **Address Sexual Violence and Support Survivors:** Programs should be established to address the issue of sexual violence and provide adequate support for survivors. This includes ensuring access to reproductive health services, abortion inclusive, for those affected by non-consensual encounters, as well as providing counselling and resources to aid in their recovery.

(vii) **Socioeconomic and Informational Barriers:** Policymakers should recognize and address the broader socio-demographic factors that influence reproductive decision-making, such as socioeconomic status and access to information. Efforts should aim to improve access to resources and services for all women, particularly those in marginalized communities.

5.5 Limitations of the study

The study's quantitative approach may have overlooked the importance of qualitative methods, resulting in a lack of nuanced understanding of women's experiences and barriers in accessing abortion services.

The study also faced language barriers due to some respondents being illiterate, despite the researcher's efforts to interpret the questionnaire.

Respondents' reputation concerns led to information barriers in the study, affecting the accuracy and completeness of collected information, potentially influencing the study outcomes due to concealment of certain details.

The study had a cross-sectional limitation because it only recorded data at a specific moment, which could lead to the omission of temporal changes or dynamics. This limitation also suggested the need for complementary longitudinal or qualitative studies for a more comprehensive understanding.

5.6 Areas for further research

There are several avenues for future research that have the potential to deepen our comprehension and contribute to the advancement of knowledge in this particular domain.

Longitudinal Studies on Abortion Trends: Conducting longitudinal studies that track changes in abortion rates and the factors influencing these trends over time can provide valuable insights. This research could focus on how socio-demographic factors, reproductive health behaviors, and access to healthcare services evolve, helping to identify patterns and inform future policies.

Impact of Policy Changes on Abortion Access: Investigating the effects of specific policy changes on women's self-induced abortion services can yield important findings. This study could analyze how legislative shifts, such as changes in funding for reproductive health services or

alterations in legal restrictions, impact the rates of safe and unsafe abortions among different demographic groups.

Cultural Influences on Reproductive Health Decisions: Exploring the cultural beliefs and practices that influence women's decisions regarding abortion can enhance understanding of the barriers they face.

Men's Perspectives on Reproductive Health: Examining men's roles and perspectives in reproductive health decisions, particularly regarding abortion, can provide a more comprehensive understanding of the dynamics involved. Research could focus on how men's attitudes and behaviors influence women's choices and self-induced abortion services.

Effectiveness of Educational Interventions: Evaluating the effectiveness of different educational interventions aimed at improving knowledge about reproductive health and safe abortion practices is crucial. This study could assess various formats, such as community workshops, school-based programs, and online resources, to determine which methods are most effective in reaching and educating women.

Mental Health Outcomes Post-Abortion: Investigating the mental health outcomes of women who undergo abortions can provide insights into the psychological impacts of the procedure. This study could focus on exploring the factors that lead to positive or negative mental health, helping to inform support services for women post-abortion.

Role of Technology in Reproductive Health: Exploring how technology, such as telemedicine and mobile health applications, influences access to reproductive health services, including abortion, can provide insights into modern healthcare delivery. This study could assess the effectiveness and acceptance of these technologies among women of reproductive age.

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APPENDIX I: Research Consent Form

CONSENT FORM

Study Title: Factors Associated with self-induced Abortions among Women of Reproductive Age (15-49) Years in Jinja Regional Referral Hospital- Jinja City

Researcher: Arongat Esther Omoding

You are being selected to participate in my research study that aims to explore the Factors Associated with self-induced Abortions among Women of Reproductive Age (15-49) Years in Jinja Regional Referral Hospital- Jinja City. Your participation in this study is voluntary, and this form is designed to provide you with information about the study purpose, procedures, risks, benefits, and your rights as a participant. Please read this form carefully and feel free to ask any questions before deciding whether to participate.

The purpose of this study is to gather insights into the Factors Associated with Self-induced Abortions among Women of Reproductive Age of 15-49 Years in Jinja Regional Referral Hospital. By understanding your perspectives and experiences, we hope to improve Access to Abortions among Women of Reproductive Age of 15-49 Years in Uganda.

If you agree to participate, you will be asked to:

- Complete a questionnaire or participate in an interview to share your knowledge, about the access to abortions among women of reproductive age of 15-49 Years.
- Your responses will be recorded anonymously and used for research purposes only.

- The data collected will be analyzed to identify common themes and patterns related to vaccination practices.

There are minimal risks associated with participating in this study, such as potential discomfort or emotional distress when discussing access to abortion experiences. However, your participation may contribute to enhancing access to abortion and improving health of women of reproductive age of 15-49 Years in the community.

Your participation in this study will be kept confidential. Your responses will be anonymized, and any personal information collected will be stored securely and accessible only to the researcher. Your identity will not be disclosed in any research reports or publications.

Participation in this study is entirely voluntary. You have the right to refuse to participate or withdraw from the study at any time without consequences. Your decision will not affect your access to healthcare services at Jinja Regional Referral Hospital.

If you have any questions about the study or your participation, please contact: Arongat Esther Omoding

I have read and understood the information provided in this consent form. I voluntarily agree to participate in the research study on Factors Associated with Access to Abortions among Women of Reproductive Age of 15-49 Years in Jinja Regional Referral Hospital- Jinja City.

Participant's Name: _____ Participant's Signature: _____
Date: _____

I have explained the study purpose, procedures, risks, benefits, and participant rights to the individual named above. I confirm that they have voluntarily agreed to participate in the study.

Researcher's Name: _____ Researcher's Signature: _____
Date: _____

Please keep a copy of this consent form for your records.

Thank you for your participation in this study.

APPENDIX II: Questionnaire

Dear Respondent,

I am **ARONGAT ESTHER OMODING** a student at Uganda Christian University pursuing Masters of Public Health. In order to complete the study, I am kindly requesting you to take off a few minutes to participate in this research study. After your consent, I am kindly asking you to fill out the questionnaire at your most convenient time. This study is aimed at investigating the factors associated with self-induced abortions among women of reproductive age of 15-49 years in Jinja regional referral hospital. All information provided will be treated with utmost confidentiality. Your participation in this study is voluntary but I will be glad if you accept to participate in it.

SECTIONA: Demographic profile of respondents

Please fill and tick (√) where applicable.

1. In which Age bracket do you belong? (i). 15-24years ☐ (ii). 25-34years ☐
   (iii). 35- 44years ☐(iv) 45- Plus years ☐
2. What is your Highest Educational level attained? (i) No education ☐ (ii) Primary ☐
   (iii) O-Level ☐(iv) A-Level ☐ (v) Diploma ☐ (vi) Bachelor's degree ☐
   (vii) Master degree ☐

Section B: FACTORS ASSOCIATED WITH SELF-INDUCED ABORTIONS AMONG WOMEN OF REPRODUCTIVE AGE OF 15-49 YEARS

Please use the rating scale 1-5 as provided below to select an option that you consider most appropriate. Tick (√) the most appropriate number.

1. Strongly disagree (SD) 2. Disagree (D) 3. Not sure (NS) 4. Agree (A) 5. Strongly agree (SA)

AWRA	**Self-induced Abortions among Women of Reproductive Age of 15-49 Years**					
IAS	**Self-Induced Abortion Services**	**SD**	**D**	**NS**	**A**	**SA**
IAS.1	I easily access induced abortion services	**1**	**2**	**3**	**4**	**5**
IAS.2	I have ever used medication and induction abortion to abort the foetus	**1**	**2**	**3**	**4**	**5**

IAS.3	There costs involved in accessing induced abortion services	**1**	**2**	**3**	**4**	**5**
IAS.4	I am aware of the potential risks and complications associated with induced abortion procedures	**1**	**2**	**3**	**4**	**5**
IAS.5	The societal attitudes and stigmas impact access to induced abortion services	**1**	**2**	**3**	**4**	**5**
SA	**Surgical Abortion**	**SD**	**D**	**NS**	**A**	**SA**
SA.1	The gestational age of the pregnancy affects the choice of surgical abortion method	**1**	**2**	**3**	**4**	**5**
SA.2	The cost of surgical abortion varies based on the method and healthcare provider	**1**	**2**	**3**	**4**	**5**
SA.3	Healthcare providers provide counselling and support for individuals undergoing surgical abortion	**1**	**2**	**3**	**4**	**5**
SA.4	Access to surgical abortion services vary in urban and rural areas	**1**	**2**	**3**	**4**	**5**
SA.5	The ethical considerations surrounding surgical abortion impact healthcare practices					
M	**Miscarriages**	**SD**	**D**	**NS**	**A**	**SA**
M.1	I have had miscarriage in childbirth	**1**	**2**	**3**	**4**	**5**
M.2	Lifestyle factors influence the risk of experiencing a miscarriage	**1**	**2**	**3**	**4**	**5**
M.3	Healthcare providers diagnose and manage miscarriages	**1**	**2**	**3**	**4**	**5**
M.4	There is medical treatments available for individuals experiencing recurrent miscarriages	**1**	**2**	**3**	**4**	**5**
M.5	Societal beliefs around miscarriages influence the support and care provided to individuals	**1**	**2**	**3**	**4**	**5**

SMA	**SELF-INDUCED ABORTION**					
PC	**Parental Consent**	**SD**	**D**	**NS**	**A**	**SA**
PC.1	There are potential barriers faced by minors seeking self-managed abortion without parental consent	**1**	**2**	**3**	**4**	**5**
PC.2	Healthcare providers navigate the issue of parental consent in self-managed abortion for minors	**1**	**2**	**3**	**4**	**5**
PC.3	The ethical considerations surrounding parental consent in self-managed abortion	**1**	**2**	**3**	**4**	**5**
PC.4	The lack of parental consent impacts the safety and access to resources for individuals seeking self-managed abortion	**1**	**2**	**3**	**4**	**5**
PC.5	I make informed decisions about self-managed abortion in the absence of parental consent	**1**	**2**	**3**	**4**	**5**
LR	**Legal Restrictions**	**SD**	**D**	**NS**	**A**	**SA**
LR.1	The legal restrictions on self-managed abortion methods in different countries	**1**	**2**	**3**	**4**	**5**
LR.2	Legal restrictions impact access to safe and reliable information on self-managed abortion	**1**	**2**	**3**	**4**	**5**
LR.3	Legal restrictions on self-managed abortion affect marginalized communities and individuals with limited access to healthcare	**1**	**2**	**3**	**4**	**5**
LR.4	Legal restrictions on self-managed abortion intersect with other reproductive rights issues, such as access to contraception and sexual education	**1**	**2**	**3**	**4**	**5**
LR.5	Advocacy efforts are in place to challenge and reform legal restrictions on self-managed abortion	**1**	**2**	**3**	**4**	**5**
PI	**Peer Influence**	**SD**	**D**	**NS**	**A**	**SA**

PI.1	Peer influence impact the decision-making process of individuals considering self-managed abortion	**1**	**2**	**3**	**4**	**5**
PI.2	Peer networks and online communities play in providing support and information on self-managed abortion	**1**	**2**	**3**	**4**	**5**
PI.3	Peer experiences and testimonials influence individuals' perceptions and attitudes towards self-managed abortion	**1**	**2**	**3**	**4**	**5**
PI.4	Healthcare providers engage with peer networks to provide accurate information and resources on self-managed abortion	**1**	**2**	**3**	**4**	**5**
PI.5	Peer pressure and social norms within peer groups affect individuals' choices regarding self-managed abortion	**1**	**2**	**3**	**4**	**5**
HWE	**Health worker experience**	**SD**	**D**	**NS**	**A**	**SA**
HWE.1	Healthcare workers face challenges in providing support and care for individuals who have self-managed abortion	**1**	**2**	**3**	**4**	**5**
HWE.2	Healthcare workers address the needs of individuals seeking care after self-managed abortion	**1**	**2**	**3**	**4**	**5**
HWE.3	Healthcare workers ensure confidentiality and privacy for individuals disclosing self-managed abortion experiences	**1**	**2**	**3**	**4**	**5**
HWE.4	There are barriers that healthcare workers face in providing non-judgmental and compassionate care to individuals who have self-managed abortion	**1**	**2**	**3**	**4**	**5**
HWE.5	Healthcare policies and practices should be improved to enhance the quality of care for individuals who have self-managed abortion	**1**	**2**	**3**	**4**	**5**
SDF	**SOCIO-DEMOGRAPHIC FACTORS**					
A	**Age**	**SD**	**D**	**NS**	**A**	**SA**
A.1	There are barriers faced by younger women (15-24 years) in accessing safe and legal abortion services	**1**	**2**	**3**	**4**	**5**

A.2	Age affect the availability of support networks and resources for women seeking abortions	**1**	**2**	**3**	**4**	**5**
A.3	Age influence the timing and gestational age at which women seek abortion services	**1**	**2**	**3**	**4**	**5**
A.4	There are age-related stigma and discrimination on the access to abortion services	**1**	**2**	**3**	**4**	**5**
A.5	There are differences in access to abortion services based on age across urban and rural areas	**1**	**2**	**3**	**4**	**5**
MS	**Marital status**	**SD**	**D**	**NS**	**A**	**SA**
MS.1	Marital status influences the decision-making process and access to abortions among women of reproductive age (15-49 years)	**1**	**2**	**3**	**4**	**5**
MS.2	There is equitable access to abortion services regardless of marital status among women of reproductive age	**1**	**2**	**3**	**4**	**5**
MS.3	Marital status impact the availability of support systems and resources for women seeking abortions	**1**	**2**	**3**	**4**	**5**
MS.4	There are barriers faced by unmarried or divorced women in accessing safe and legal abortion services	**1**	**2**	**3**	**4**	**5**
MS.5	Spousal consent plays a lot in the access to abortions for married women.	**1**	**2**	**3**	**4**	**5**
PR	**Place of residence**	**SD**	**D**	**NS**	**A**	**SA**
PR.1	The place of residence (urban, rural, etc.) impact access to abortion services for women of reproductive age (15-49 years)?	**1**	**2**	**3**	**4**	**5**
PR.2	Living in rural areas affect the availability of abortion clinics and healthcare facilities for women seeking abortions	**1**	**2**	**3**	**4**	**5**

PR.3	Women in rural areas face challenges of transportation and logistics in accessing abortion services	**1**	**2**	**3**	**4**	**5**
PR.4	Social norms in different places impact access to abortion services for women of reproductive age	**1**	**2**	**3**	**4**	**5**
PR.5	Telemedicine and digital health solutions bridge the gap in access to abortion services between urban and rural areas	**1**	**2**	**3**	**4**	**5**
E	**Employment**	**SD**	**D**	**NS**	**A**	**SA**
E.1	Unemployed or underemployed women face barriers in accessing abortion services	**1**	**2**	**3**	**4**	**5**
E.2	Working hours and scheduling constraints affect the ability of women to seek abortion services	**1**	**2**	**3**	**4**	**5**
E.3	Employment status influence the ability to access abortion services for women of reproductive age (15-49 years)?	**1**	**2**	**3**	**4**	**5**
E.4	Job stability and benefits impact the decision-making process of women seeking abortions	**1**	**2**	**3**	**4**	**5**
E.5	Workplace accommodations and support programs improve access to abortion services for employed women	**1**	**2**	**3**	**4**	**5**
RHB	**REPRODUCTIVE HEALTH BEHAVIORS**					
MSP	**Multiple Sex Partners**	**SD**	**D**	**NS**	**A**	**SA**
MSP.1	I have ever had multiple sex partners	**1**	**2**	**3**	**4**	**5**
MSP.2	Multiple sex partners influence reproductive health behaviors and access to abortion services for women of reproductive age (15-49 years)	**1**	**2**	**3**	**4**	**5**

MSP.3	Communication and negotiation with multiple sex partners impact contraceptive use and access to abortion services	**1**	**2**	**3**	**4**	**5**
MSP.4	Awareness about sexually transmitted infections play in the decision-making process of women with multiple sex partners seeking abortions	**1**	**2**	**3**	**4**	**5**
MSP.5	Healthcare providers address the unique needs and concerns of women with multiple sex partners seeking abortion services	**1**	**2**	**3**	**4**	**5**
NCS	**Non-Consensual Sex**	**SD**	**D**	**NS**	**A**	**SA**
NCS.1	Non-consensual sex impact reproductive health behaviors and access to abortion services	**1**	**2**	**3**	**4**	**5**
NCS.2	Trauma from non-consensual sex influence the ability of women to seek and access abortion services	**1**	**2**	**3**	**4**	**5**
NCS.3	Survivors of non-consensual sex face difficulties in disclosing their experiences and seeking abortion care	**1**	**2**	**3**	**4**	**5**
NCS.4	Healthcare providers provide trauma-informed care to women who have experienced non-consensual sex and are seeking abortions	**1**	**2**	**3**	**4**	**5**
NCS.5	Victim-blaming impact access to abortion services for survivors of non-consensual sex	**1**	**2**	**3**	**4**	**5**
AC	**Access to Contraception**	**SD**	**D**	**NS**	**A**	**SA**
AC.1	Barriers to accessing contraception lead women to seek abortions instead	**1**	**2**	**3**	**4**	**5**
AC.2	The availability of different contraceptive methods impacts the decision-making process of women regarding abortion services	**1**	**2**	**3**	**4**	**5**

AC.3	Awareness about contraception play a role in preventing the need for abortions among women of reproductive age	**1**	**2**	**3**	**4**	**5**
AC.4	Healthcare providers promote and facilitate access to effective contraception	**1**	**2**	**3**	**4**	**5**
AC.5	Interventions are needed to improve access to a wide range of contraceptive options	**1**	**2**	**3**	**4**	**5**
USP	**Unsafe Sex Practices**	**SD**	**D**	**NS**	**A**	**SA**
USP.1	There are risks associated with unsafe sex practices in terms of unintended pregnancies and the need for abortions	**1**	**2**	**3**	**4**	**5**
USP.2	Lack of access to sex education contribute to unsafe sex practices and abortion	**1**	**2**	**3**	**4**	**5**
USP.3	Limited access to contraception and preventive measures increased the prevalence of unsafe sex practices and abortions	**1**	**2**	**3**	**4**	**5**
USP.4	Unsafe sex practices impact reproductive health behaviors and the likelihood of seeking abortions	**1**	**2**	**3**	**4**	**5**
USP.5	Education and empowerment of women reduce the risk of unintended pregnancies	**1**	**2**	**3**	**4**	**5**

Thank you for your cooperation.

APPENDIX III: Krejcie and Morgan Table for Sample Selection

N	S	N	S	N	S	N	S	N	S
10	10	100	80	280	162	800	260	2800	338
15	14	110	86	290	165	850	265	3000	341
20	19	120	92	300	169	900	269	3500	246
25	24	130	97	320	175	950	274	4000	351
30	28	140	103	340	181	1000	278	4500	351
35	32	150	108	360	186	1100	285	5000	357
40	36	160	113	380	181	1200	291	6000	361
45	40	180	118	400	196	1300	297	7000	364
50	44	190	123	420	201	1400	302	8000	367
55	48	200	127	440	205	1500	306	9000	368
60	52	210	132	460	210	1600	310	10000	373
65	56	220	136	480	214	1700	313	15000	375
70	59	230	140	500	217	1800	317	20000	377
75	63	240	144	550	225	1900	320	30000	379
80	66	250	148	600	234	2000	322	40000	380
85	70	260	152	650	242	2200	327	50000	381
90	73	270	155	700	248	2400	331	75000	382
95	76	270	159	750	256	2600	335	100000	384

Note- N is Population Size, S is Sample size

Source: Krejcie & Morgan, 1970

APPENDIX IV: University Approval Notice

UGANDA CHRISTIAN UNIVERSITY
A Centre of Excellence in the Heart of Africa

UG-REC-026 Approval Version 4.0 27th June, 2024

27th June, 2024

Omoding Esther
Uganda Christian University
0777160383
Email omodingesther5@gmail.com

UG-REC-026 APPROVAL NOTICE

To: Omoding Esther, Principal Investigator

Re: UCU-REC Application titled: **In Jinja Regional Referral Factors Associated With Access To Abortions Among Women Of Reproductive Age Of 15-49 Years Hospital- Jinja City**

Application Number: **UCUREC-2024-913-1**
Version: 4.0

UGANDA CHRISTIAN UNIVERSITY APPROVED UNTIL 27 JUN 2025 RESEARCH ETHICS COMMITTEE

Type: [ ] **Initial Review**
[ ] Protocol Amendment
[ ] Letter of Amendment (LOA)
[ ] Continuing Review
[ ] Material Transfer Agreement
[ ] Other, Specify:

I am pleased to inform you that the **UG-REC-026;** UCUREC approved the above referenced application.

Approval of the research is for the period from **27th June, 2024**, to **27th June, 2025**
This research is considered minimal risk category.
As Principal Investigator of the research, you are responsible for fulfilling the following requirements of approval:

1. All co-investigators must be kept informed of the status of the research.
2. Changes, amendments, and additions to the protocol or the consent form must be submitted to the REC for re-review and approval **prior** to the activation of the changes. The REC application number assigned to the research should be cited in any correspondence.
3. Reports of unanticipated problems involving risks to participants or other must be submitted to the REC. New information that becomes available which could change the risk: benefit ratio must be submitted promptly for REC review.
4. Only approved consent forms are to be used in the enrollment of participants. All consent forms signed by subjects and/or witnesses should be retained on file. The REC may conduct audits of all study records, and consent documentation may be part of such audits.

5. Regulations require review of an approved study not less than once per 12-month period. **Therefore, a continuing review application must be submitted to the REC eight weeks prior to the above expiration date of 27th June, 2025 in order to continue the study beyond the approved period.** Failure to submit a continuing review application in a timely fashion may result in suspension or termination of the study, at which point new participants may not be enrolled and currently enrolled participants must be taken off the study.
6. The REC application number assigned to the research should be cited in any correspondence with the REC of record.
7. Your research details have been shared with the Executive secretary of Uganda National Council for Science and Technology (UNCST) and you are **not** required to get clearance since you are a Masters Degree research. Refer to UNCST Research registration and clearance Policy and guidelines (July 2016) in Uganda section 6(e).

The following is the list of all documents approved in this application by **UG-REC _026:**

	Document Title	Language	Version	Version Date
1.	**Protocol**	**English**	1.0	2024-06-19
2.	Data Collection tools	English	1.0	2024-06-10
3.	Informed consent form	English	1,0	2024-06-19

Signed and Stamped

Prof. Peter Waiswa.
UCUREC Chairperson,
pwaiswa@musph.ac.ug

UGANDA CHRISTIAN UNIVERSITY
APPROVED
"INTI"
27 JUN 2025
RESEARCH ETHICS COMMITTEE

APPENDIX V: Clearance Letter from Jinja Regional Referral Hospital

MINISTRY OF HEALTH

JINJA REGIONAL HOSPITAL

JINJA HOSPITAL RESEARCH AND ETHICS COMMITTEE (JRRH-REC)

1st July, 2024

Our Ref: JRRH-REC 516/2024

To
Ms. Arongat Esther Amoding
Investigator

Dear Madam.,

RE: APPROVAL TO DO DATA COLLECTION AT JINJA REGIONAL HOSPITAL

I am glad to let you know that after reading through your research proposal titled:-
"Factors asscoaited with access to abortions among women of reproductive age of 15 to 49 atat at Jinja Regional Referral Hospital-Jinja city ", I have found your study to be meeting the minimum technical and ethical standards for doing research at Jinja Regional Referral hospital.
I hereby grant you approval to do data collection. Please note that all research undertakings should comply with guidelines for protection of human subjects in research.
This approval is granted under registration number ***JRRH-REC* 516/2024** and should never be used for any other research process in the hospital apart from this study.
During the study period, keep in touch with the chairperson Jinja Hospital Research and Ethics Committee Dr. Tagoola Abner 0772408100 for any inquiries or email the secretary kasib4god@gmail.com and share a copy of your research findings on the same email.

Yours Sincerely,

pp Dr. Tagoola Abner (Sen. Cons. Paed)
Chairperson JREC
cc. file

OFFICE OF THE CHAIRPERSON
APPROVED
VALID UNTIL
02 JUL 2025
JINJA REGIONAL REFERRAL HOSPITAL
RESEARCH & ETHICS COMMITTEE
(JRRH - REC)

Page 1 of 1

APPENDIX VI: Estimated Budget for the research

S/N	Particulars	Quantity	Unit Cost	Amount
			Ugx	**Ugx**
1	Printing and binding proposal	04	40,000	160,000=
2	Printing and photocopying of items/questionnaires	327	600	196,200=
3	Data Analysis			1,000,000=
4	Data collection (Transport)			400,000=
5	Printing and binding final dissertation	04	100,000	400,000=
6	Other expenses			300,000=
	TOTAL			**2,456,200=**

APPENDIX VII: Research Work Plan

ACTIVITIES	APRIL	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
Proposal development and submission											
Data collection											
Data analysis											
Report handling and Submission											
Viva voce											
Final correction and submission											