KNOWLEDGE, ATTITUDE, AND PRACTICE OF ABORTION IN XAI-XAI COMMUNITIES, MOZAMBIQUE

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ABSTRACT

A community survey of about 400 women in selected Xai-Xai communities in 2006 indicates that abortion is highly prevalent, about 20% women had had an abortion in their lifetime, and 40% reported that they know someone who also had an abortion. Yet, talking about abortion is avoided in the community because it is still considered a sin and a "dirty topic." Lack of family planning was the single biggest reason for abortion followed by "health reasons." Misconceptions include women's inability to regain childbearing capacity following an abortion. About two-thirds of women who had an abortion said that it was performed by medically trained providers. However, about 50% abortion-seekers reported complications, from mild to severe. About 25% women who had an abortion faced stigma-related familial and/or social problems. Based on the findings, counseling information for community workers and health providers was enriched, and policy dialogues and advocacy strategies were strengthened.

BACKGROUND

The poor reproductive health status in Mozambique is indicated by the country's low contraceptive use, high fertility, high maternal mortality, and other related indictors (PRB 2006, UN 2005, WHO 2004). On average, a woman gives birth to 4.4 children in urban areas and 6.1 children in rural areas. However, wanted fertility is also high: on average a woman wants to have 3.8 and 5.5 children in urban and rural areas, respectively. About 50% of women in urban areas and 30% in rural areas desire contraception, leaving quite a high level of unmet need for contraception of 20% and 18% in urban and rural areas, respectively. Given the high unmet need for contraception, women are likely to have unintended pregnancies and thus abortion.

Maternal mortality is high in Mozambique. WHO estimates show the maternal mortality ratio was about 1,000 per 100,000 live births in 2000 (WHO 2004). However, the Mozambique Demographic and Health Survey 2003 estimated an MMR of slightly over 400 per 100,000 (MDHS 2003). The high maternal mortality is associated with many interrelated factors -- poverty, high fertility, prevalence of young motherhood, an undeveloped health care system and insufficient trained providers, especially in rural areas. But many maternal deaths are likely to be the result of unsafe abortion.

The status of abortion in Mozambique can be termed "quasi-legal" (Agadjanian, 1998)." The criminal code requires punishment if abortion is obtained or provided except when the mother's health or life is at risk. However, since the early 1980s the MOH has agreed to allow the provision of abortion upon request when women's physical and/or mental health is adversely affected by the pregnancy. The rationale behind the MOH policy is presumed to deal with the widespread unsafe abortion and its consequences for women's health.

Abortion in Mozambique is most common among single women with or without a partner. It is common among younger women, especially ages 15-24 (Machungo et al.

1997). Abortion is practiced for both delaying and spacing births and limiting fertility, but the former is more common than the latter (Agadjanian 1998).

Abortion is provided at selected health facilities (central, provincial, and general hospitals) upon request. But barriers to seeking abortions at such facilities are many, including women lacking information about the services, bureaucratic procedures, and costs for transportation and health services. Because of these barriers, women who are single, young, poor, or from rural areas, opt for unsafe abortion provided by untrained traditional healers.

Inadequate health infrastructure exacerbated by poor quality of services makes it difficult for women to receive abortion or post-abortion care services in Mozambique. Facilities lack effective infection prevention procedures; there are few trained health providers; and use of D&C is more common than MVA, a more appropriate method of abortion in the first trimester. (Gallo et al. 2004; Newman et al. 1998).

THE PATHFINDER APPROACH TO SAFE ABORTION AND POST-ABORTION CARE (PAC) SERVICES IN GAZA

Pathfinder International Mozambique began a project on safe abortion and PAC services in Gaza Province in April, 2005, with an aim to increase access to abortion care by improving the quality of services offered and by expanding and improving health care seeking behavior in communities. The project works primarily with three target groups: community activists, traditional healers and medical providers. Trainings for each of the above groups provide accurate and up to date information on reproductive health and abortion services. The project's technical advisors work to advocate for changes in abortion policy and to develop cohesive abortion protocols for traditional healers to refer for safe abortion and post-abortion care, and medical providers to provide safe, comprehensive services. Financial resources are used to make physical improvements to medical facilities and to purchase basic medical supplies. Provincial and district level Ministry of Health officials are actively involved in every step of the process. In this way, the project utilizes political, social and medical spheres of influence to change social norms around abortion and post abortion care.

The Community Work

In the community, the project has trained activists from five different community-based associations: "*Organizacao Mulheres Mozambicanas,*" "*Ametramo,*" "*Reencontro,*" "*Kuvumbana,*" and "*Activa.*" An average of 30 activists were trained from each association over the past two years of the project. Activists were trained on issues specific to reproductive health and family planning, with a focus on abortion and post-abortion care. Training methodology encourages discussion, eliciting information and participation from the activists and using social and cultural norms as the starting point for talking about the risks and consequences of unsafe abortion. Topics such as stigma and shame are addressed directly, as are common myths surrounding abortion and HIV/AIDS as a linked risk factor of unsafe abortion. Trained activists then conduct face-

to-face and group events around reproductive health themes with members of their associations and others in their communities. Group events vary in tactic, from interactive theatre to public debates. In the past, group debates have focused on such topics as socio-cultural beliefs about abortion, the consequences of unsafe abortion and how to avoid it, access to and use of modern family planning methods, methods of obtaining medical abortion, and HIV/AIDS prevention. Monitoring meetings are held regularly with activists to offer technical support. These meetings provide a space to discuss dealing with doubts, difficulties, and experiences with the project. They serve to keep momentum and motivation for the volunteer community activists.

The Traditional Healers

In its work with traditional healers, the CAC project seeks to strengthen ties between the traditional healers and other medical practitioners and to increase access to current information on abortion and post abortion care, but primarily to decrease the harm traditional healers cause by themselves providing unsafe abortion. Over the duration of the project, four trainings were conducted with members of the Association of Traditional Healers of Mozambique. Trainings focused on the risks of clandestine abortion, how to reduce transmission of HIV/AIDS, and how to address stigma and discrimination in the community against women who have had an abortion or who are HIV positive. Trainings also included education on how to identify someone who has experienced unsafe abortion and how to connect her to appropriate medical services and also how to refer women who need safe abortion. Group activities focused on improving healers' abilities to facilitate debates on these sensitive subjects in their communities. In addition to trainings, project consultants expanded and updated the sections addressing family planning and abortion in the Ministry of Health training manual provided for traditional healers and taught the new protocols to the healers.

The Medical Providers

Project approaches for medical providers aims to improve the quality of services rendered as well as to increase the quantity of services performed. Over the course of the project, five trainings were held for medical professionals, with three held within the first year of the project. Participants included nurses and medical technicians specializing in mother and child health. The general objective of the trainings was assisting women with differing abortion situations, focusing on post abortion care. Specifics of the training courses included how to perform manual vacuum aspiration technique, how to manage the complications of both safe and unsafe spontaneous and induced abortions, the practical aspects of how to integrate family planning and STI detection and treatment into abortion services, pre- and post- abortion counseling, and referral for other related and needed services. Trainings covered how to store and sterilize materials, as improper maintenance of MVA equipment was discovered during the project's initial overview of abortion services. Basic materials were bought for the hospital such as gloves, gowns, masks, protective eyewear, MVA syringes, and surgical sheets. The purchased materials not only improved the working conditions of the practitioners but contributed to an increase in self-esteem and pride in work.

OBJECTIVE OF THE PRESENT STUDY

The primary objective of the study was to understand the beliefs and perceptions about abortion , awareness of the abortion law, and the level of practice of abortion in selected communities of Xai-Xai City prior to the Pathfinder project began its community-based interventions. The findings helped increase the efficiency of Pathfinder International's facility- and community-based interventions on reproductive health, especially Comprehensive Abortion Care (CAC) and related services.

METHODS

A total of 388 women between ages 15 and 49 years were randomly selected from the neighborhoods of Marien Gouabi Suburb A and B, Dambine 2000 Suburb, and Zona Baixa of Xai-Xai City. (The localities have access to a health center that provides Post-Abortion Care (PAC).) Information on reproductive health was collected from the sample women at their homes by trained and experienced female data interviewers through a structured questionnaire in Portuguese. The field work was done during May-June 2006. The data were processed and analyzed in SPSS .

Sample characteristics

Median age of the survey sample was 26 years. About 44% were single, 37% were married or lived in a union, and 19% were separated, divorced, or widowed. About 38% did not have any education, 33% had primary-school education, and the rest 39% had secondary-school education. All the respondents resided in the city or suburb, but over 80% of them were slum dwellers.

FINDINGS

The findings are described in three broad areas: 1) Stigma, beliefs, and perceptions around abortion; 2) knowledge and perception of abortion law; and 3)practices, reasons for, and complications from abortion.

Stigma, belief, and perception about abortion

We attempted to understand to what extent abortion is talked about in the community. According to Table 1.1, only about one in three respondents (32%) said that women talk with each other about abortion issues. Among those 32%, one in five said that it is widely discussed, over half said that it is discussed sometimes, and one in five said that it is rarely discussed. Only one in ten respondents said that women who obtain an abortion talk about it or disclose it in the community. All respondents were asked "why women don't talk about abortion in the community." There were multiple answers to this question: 41% said shame; 28% said it is a sin; and 23% said it is a "dirty topic" to talk about.

In answer to the question whether women can have an abortion, only 4% said that it can be done, 6% said it can be done under certain circumstances, and 14% said it is up to an individual to decide. Over two-third (68%) said that it is sin or it should not be done.

Women do perceive of consequences of abortion. Over two-third of respondents said abortion can lead to death. Less than half (45%) believed that abortion-seekers may not be able to get pregnant again and over one quarter believed that the uterus may be "weakened" following an abortion. Another one quarter believed that women may develop infections or may become physically weak.

Only a few respondents (8%) thought that it is common for women in their community to practice abortion. About one-quarter said it not so common, and over a half said it is rare or very rare for women to seek abortion. In a probing question whether abortion was sought even rarely, only less than one in five respondents confirmed that women seek abortion in their community.

A question was asked; under what circumstances abortion may be obtained. Table 1.5 shows that 30% said that it can be obtained in the case of incest or rape and another 29% said it can be obtained on :health grounds." It may be obtained in the case of unexpected or accidental pregnancy (25%) or for birth spacing or limiting (31%). It may also be obtained in the case of extramarital pregnancy (9%) or contraceptive failure (5%).

In a question related to duration of pregnancy and abortion, over 70% said that abortion can be sought or is performed, or is safe when done in less than 3 months of pregnancy.

Knowledge or perception of abortion law

Only 20% of respondents reported that abortion is allowed according to the law in Mozambique; 60% said that abortion is not legal and another 20% said that they do not know. To the question "Under what circumstances is abortion allowed by the law?" about half said that the law may allow abortion for a woman who experiences grave injury to her physical or mental health. A quarter of women said abortion may be allowed in case of a pregnancy following a rape. One in six women said that the law may allow abortion in case of ill health of the fetus. And, one in eight said that abortion may be allowed in cases of contraceptive failure.

A question was asked, "Who is allowed to perform abortion?" With an option of multiple answers, about 60% and 55% replied that "specialized doctors" and "doctors," respectively, are allowed to perform abortion. Additionally, about 45% said that nurses are allowed to perform abortion.

Whose permission is necessary to have an abortion? About one in ten said that a guardian's permission is needed if the woman is a minor. Three in four said that permission is required only if a woman is mentally ill. About one in seven said that they do not know.

Practice of abortion and related experiences

Table 3.1 shows that about two in ten women had an abortion in their lifetime. Moreover, about four in ten women said that they know someone who had an abortion. Therefore it appears that abortion is, in fact, practiced often by women in the communities under study.

The reasons for abortion range from family planning, to health, to social. With an option of multiple answers, a majority (55%) of women who had an abortion said that the reason was family planning related, and 23% cited health related reasons. Other reasons were accidental or unexpected pregnancy (12%), premarital pregnancy (14%), extramarital pregnancy (9%), and incest or rape (8%).

Table 3.3 shows the reported sources of abortion, which are obtained from three cohorts: those who had an abortion, those reported by the friend who had an abortion, and other sources known to respondents. Over one quarter (27%) of respondents said that they do not know about any source of abortion. 40% said that abortion can be obtained from a doctor or nurse, 60% said that it can be obtained from a hospital or clinic, and 20% said that it can be obtained from a traditional healer. Regarding where "the friend" sought an abortion, one in seven said that their friend obtained an aborton from a doctor or a nurse, four in ten said that their friend obtained it from a hospital or a clinic, and two in ten said that it was obtained from a traditional healer. Additionally, about two in ten did not tell from where their friend obtained abortion services. Of respondents who themselves had had an abortion, about 50% said that they obtained it from a doctor or nurse, 20% obtained it from a hospital or clinic, and 10% obtained it from a traditional healer. In addition, 10% said they received it from other sources and another 10% did not specify the source.

Information was obtained about the methods of abortion. About two-thirds (64%) of women who had an abortion said that it was performed by a medical procedure in a health facility, 20% said it was performed by taking medicine, and 16% said that it was done by inserting material or medicine in the reproductive organ or by applying physical force. The distribution of methods of abortion of friends was almost similar to above, except that "taking medicine" for abortion was more common for "friends" than respondents and therefore "medical procedures in a health facility" were less common among "friends" than respondents.

About half of the women or their friends who had an abortion experienced complications following an abortion. Complications ranged from minor to severe bleeding, backache to abdominal pain, high fever, infection or sepsis, incomplete abortion, and "general weakness."

There were social consequences of abortion; about one in four women who had an abortion faced familial and social problems. Among those who faced a problem, a half said that they were rejected by partners and the other half said that they were rejected by family.

PROJECT ACHIEVEMENTS

From July 2006 to June 2007 the Safe Abortion and Post-Abortion Care Project trained 151 community activists, including 32 traditional healers. Of the activists trained, 90% remained involved as community educators and counselors by the end of the year, showing a major improvement in the retention rate in comparison with the first year of the project. Over 250 community forums/debates were held in the district of Xai-Xai on topics relating to unsafe abortion, HIV/AIDS, and post-abortion care. The debates involved close to 5,000 participants and audience members.

Traditional healers reached 825 clients with reproductive health education, including information on safe abortion and post-abortion care. Over 1000 clients, with problems related, or traditionally believed to be related, to abortion or HIV/AIDS, were referred to health units. Traditional healers provided follow-up information and counseling through home visits to 397 clients who were referred by them to health centers.

Training was given to maternal and child health (MCH) nurses on manual intra-uterine vacuum aspiration (MVA), management of complications resulting from safe and unsafe abortions, pre- and post-abortion counseling, post-abortion contraception, and STI diagnosis and treatment.

In addition, the Pathfinder project played a role in the qualification process of PAC services at the provincial hospital in Xai-Xai. The process aims at establishing and maintaining standards of quality of services and serves as a monitoring and evaluation component of the program. The project purchased basic medical supplies and supplies relating to PAC/abortion services.

Since the start of the Project, there has been an overall increase in the use of both PAC and abortion services. While the pattern of CAC use reflects seasonal variation in fertility and fecundity, looking at use over time there is an observable increase in use of PAC services, even in comparing the first year of the project to the second.

One of the greatest successes of the Pathfinder project has been women's increased use of contraception following an abortion. Most women receiving abortion or PAC services now have a contraceptive method to use. This will reduce further unwanted pregnancies and repeat abortions.

DISCUSSION

The survey findings helped develop interventions of the safe abortion and PAC project in Gaza Province, especially in designing training curriculum and counseling materials for community workers and health providers. The findings also helped develop policy dialogue and advocacy strategies for health managers, community leaders, and policy planners.

Our findings are consistent with the common belief that abortion is highly prevalent in Mozambican communities (the survey showed about one in five women between 15 and 49 years of age had had an abortion in their lifetime, and two in five reported that they know someone who also had an abortion.) It is also consistent with the notion that stigma is attached to abortion because many people are reluctant to talk about and many respondents associate abortion with sin, shame and a "dirty topic."

Women also had negative opinions about abortion – 24% said that abortion should not be done and 44% said that having abortion is a sin. Only 24% said that abortion can be done. The majority respondents thought that women seek abortion only in rare cases. However, respondents reported that they would agree to allow abortion under certain circumstances, which are incest or rape, health problems, unexpected or accidental pregnancies, premarital or extramarital pregnancies, birth spacing and limitation, and financial difficulties associated with a pregnancy. Therefore it seems there is a certain level of approval of abortion for reproductive health considerations. These findings support that information, counseling, and abortion and PAC services should be important componentsof an appropriately designed reproductive health program. Abortion information, counseling and services must have priority in reproductive health programs.

The findings show that women have a perception that an abortion may lead to death or subfecundity (inability to get pregnant). Information and counseling provided by the community workers and health providers should focus on the assurance that abortion provided by the trained health providers is safe and does not have health consequences including the possibility of abortion-induced subfecundity. The Pathfinder projects, through their training of health workers, give special emphasis to this aspect to remove any misconceptions or fears about safe abortion and PAC.

There are familial and social sanctions against the practice of abortion. In the survey, 25% of women who had an abortion faced familial and/or social problems. Pathfinder attempts to mobilize the community through community activists and health workers with support from community leaders in order to reduce stigma and gain support for the abortion or post-abortion clients.

Family planning (family limiting, birth spacing, or contraceptive failure) was the single major reason for abortion followed by "health reasons". This finding again points to the necessity to improve accessibility and quality of family planning services. One in five women between 15 and 49 years of age have unmet need for contraception. Women do not have enough information about contraception-service availability or they do not have access to a method when they need it. Moreover, women may not have a method of their choice or they drop a method for reasons associated with quality of contraceptive services. Enhanced access and quality of services will increase contraceptive use and thus reduce unintended pregnancies and abortion in Mozambique.

Knowledge about the abortion law is poor: only one in five women reported that abortion in legal. Women should be made aware of the changed MOH policies about the

availability of abortion services in Mozambique. Information should be given to the community through culturally appropriate channels of communication. Community workers and health providers should be trained on how this sensitive health information should be provided to women. Help from community leaders should be sought to make this information dissemination effective.

A large majority of respondents believe correctly that only medically trained providers are allowed to perform abortion. Experience shows that access to the facilities that provide safe abortion or PAC services is limited because of barriers of various kinds and instead women opt for clandestine abortion. Some barriers are: Availability of abortion only in selected hospitals like central, regional, and general hospitals, not in health centers closer to the community; Medical authorization in establishing legality of an abortion case is cumbersome and difficult to obtain; Requirement of consent from a "parent" or "responsible male" before obtaining services; Cost for abortion services is high in the hospitals; Transportation costs and time to travel to hospitals from rural areas is expensive. Abortion services in hospitals are of poor quality. Provision of abortion services at the community-level health facilities, as family planning services are available there, through trained providers by using MVA will reduce the incidence of unsafe abortion and thus maternal mortality. The community should be made aware of the correct reproductive health approaches, choices and decisions toward better health of women.

REFERENCES

Agadjanian V. "Quasi-legal" abortion services in a sub-Saharan setting:users' profile and motivations. International Family Planning Perspectives 1998;24:111-16.

Gallo MF et al. An assessment of abortion services in public health facilities in Mozambique: women's and providers' perspectives. Reproductive Health Matters 2004; 12(24 Supplement):218- 226.

Machungo F et al. Reproductive characteristics and post-abortion health consequences in women undergoing illegal and legal abortion in Maputo. Social Science and Medicine 1997;45:1607-13.

Mozambique Demographic and Health Survey 2003. Available at www.measuredhs.com.

Newman RD et al. Satisfaction with outpatient health care services in Manica Province, Mozambique. Health Policy and Planning 1998;13:174-80.

Population Reference Bureau. World population data sheet 2007. Available at www.prb.org.

United Nations Organization. World contraceptive use 2005. Available at www.unpopulation.org.

WHO, UN Children's Fund, UN Population Fund. Maternal mortality in 2000: estimates developed by WHO, UNICEF, UNFPA. Geneva: World Health Organization; 2004.

Table 1.1: Stigma around abortion

Do women in your community talk about abortion (n=338)?	
Yes	32%
No	66%
Do not know	2%
How often do they talk about abortion (n=110)?	
Widely	19%
Sometimes	53%
Rarely	20%
Do not know	8%
Do you think women who go for an abortion talk about it in the community (n=338)?	
Yes	11%
No	75%
Do not know	14%
Why don't women talk about abortion (n=338, multiple answers)?	
It is a shame	41%
Abortion is a sin	28%
It is dirty thing	23%
People are indifferent	17%
A child is a gift from God	9%
It is against religion	7%
Do not know	5%

Table 1.2: Opinion about abortion (n=338)

Abortion can be done	4%
Abortion can be done under certain circumstances	6%
It is up to the individual	14%
Abortion is a sin	44%
One should not have an abortion	24%
Other	1%
Do not know	8%

Table 1.3: Perceived consequences of abortion (n=338, multiple answers)

Women can even die	67%
Women may not become pregnant again	45%
Uterus may become weak	27%
Women can develop infections	12%
Women may become very weak	12%
Do not know	4%

Table 1.4: Perception on the practice of abortion

How common is it for women to seek abortions in your community or neighborhood (n=338)?	
Very common	3%
Common	5%
Not so common	23%
Rare	36%
Very rare	15%
Do not know	19%
Do women in your community seek abortion, even rarely (n=338)?	
Yes	18%
No	43%
Do not know	39%

Table 1.5: Beliefs under which circumstances abortion can be done (n=338, multiple answers)

Incest or rape	30%
Health problems	29%
Unexpected or accidental pregnancy	25%
Premarital pregnancy	19%
Wanting no more children	17%
Birth spacing	14%
Poverty or financial reason	11%
Extramarital pregnancy	9%
Contraceptive failure	5%
Do not know	6%

Table 1.6: Beliefs about the duration of pregnancy at which abortion is practiced or performed or it is safe (n=338)

Sources	3 months or less	4-5 months	6 months or more	Do not know or non-response
Abortion can be sought	75%	7%	9%	9%
Abortion is performed	70%	10%	2%	18%
Abortion is safe	74%	0%	0%	26%

Table 2.1: Knowledge or perception of the abortion law

What does the law say about abortion (n=338)?	
Abortion is legal	20%
Abortion is illegal	62%
Do not know	18%
According to the law, abortion is allowed in case of (n=338):	
Grave injury to physical and mental health of women	49%
Pregnancy following a rape	26%
Health of the fetus	16%
Pregnancy while using contraception	13%
Do not know	12%
Legally, who can perform abortion (n=338)?	
Specialist doctors	59%
Doctors	56%
Nurses	46%
Others	2%
Do not know	7%
Whose permission is necessary to have abortion (n=338)?	
Guardian in case of minor	11%
Guardian for mentally ill woman	75%
No permission is necessary	
Do not know	14%

Table 3.1: Level of abortion practice (n=338)

Respondents ever having an abortion	19%
Respondents knowing someone who had an abortion	41%

Table 3.2: Reasons for having an abortion (n=64)

Reasons	% (multiple answers)
Wanted a child at a later time	23%
Wanted to have more spacing between births	9%
Wanted no more children	11%
Contraceptive failure	11%
Unexpected or accidental conception	12%
Health problem(s)	23%
Premarital conception	14%
Extramarital conception	9%
Incest or rape	8%
Do not know or non-response	2%

Table 3.3: Sources of abortion services

Sources	Knowledge about sources (n=338, multiple answers)	Friend's sources of abortion (n=140)	Own sources of abortion when she had one (n=64)
Traditional healer	20%	21%	11%
Doctor/nurse	38%	14%	48%
Hospital/clinic	59%	39%	19%
Others	0%	7%	11%
Do not know or non-response	27%	19%	11%

Table 3.4: Methods used for abortion

Sources	Knowledge about methods (n=338, multiple answers)	Method used when a friend had an abortion (n=140)	Method used when respondent had an abortion (n=64)
Applying physical force, pressure, or message	5%	2%	3%
Inserting some materials or medicine in reproductive organs	27%	16%	13%
Taking medicine	25%	27%	20%
By medical procedure in a health facility	42%	44%	64%
Do not know or non-response	36%	12%	5%

Table 3.5: Level of abortion complications

Respondents having complications after an abortion (n=64)	54%
Community women having complications after an abortion (n=140)	50%

Table 3.6: Complications of abortion

Sources	Suffered by the friend who had an abortion (n=140, multiple answers)	Suffered by the respondent (n=36, multiple answers)
Mild bleeding	31%	35%
Severe bleeding	19%	15%
Backache	10%	12%
Abdominal pain	23%	24%
High fever	16%	32%
Infection/sepsis	10%	12%
Weakness/anemia	20%	24%
Incomplete abortion	24%	12%
Death	9%	--
Do not know or non-response	3%	6%

Table 3.7: Social consequences of abortion

Did your friend face any familial or social problems after having an abortion (n=140)	
Yes	27%
No	73%