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Abortion among young adults aged 18 to 25 years, attending Kajjansi Health Centre IV, A Cross-sectional Study.

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ABSTRACT

Background:

The rate of abortions in Uganda is concerning, with abortion-related deaths increasing, most especially among young mothers. This study thus focused on investigating the factors associated with increased abortions among young adults aged 18-25 years at Kajjansi Health Centre IV.

Methodology:

The study employed a cross-sectional design at Kajjansi Health Centre IV for a period of three months, from May 2025 to August 2025. An estimated 114 respondents obtained through simple random sampling participated in the study. Data was collected using a questionnaire, analyzed, and presented in the form of tables, graphs, and pie charts.

Results:

Findings revealed that the majority of the respondents were single (44.7%) or separated (17.5%), with 59.6% acknowledging that marital status influenced their decision to seek abortion. Educational attainment was relatively high, with 70.2% affirming that education affected their reproductive choices, and 85.1% reporting prior exposure to reproductive education. Despite this, 75.4% had decided to abort, and 75.4% expressed only moderate confidence in that decision.

Economic vulnerability was evident, with 74.6% of the respondents identifying as low-income and nearly one-fifth unemployed. While 48.2% cited economic status as a factor in abortion decisions, access to safe abortion services remained moderate, 57.9%, with 13.2% reporting no access at all.

Conclusion:

Financial insecurity is key in reproductive decision-making, often pushing young adults towards abortion due to the inability to support the child. Whereas unstable relationships significantly contribute to abortion, education is a double-edged factor.

Recommendation:

These findings highlight the urgent need for targeted interventions that enhance reproductive health education, economic empowerment, and access to safe abortion services within this demographic.

Keywords: *Abortion, Young Adults, Kajjansi Health Centre IV.*
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Background

Globally, around 73 million induced abortions occur each year; of these, approximately 45% are unsafe abortions. In terms of unintended pregnancies, about 61% end in induced abortions, and 3 out of 10 of all pregnancies (29%) end in induced abortion (WHO, 2O24). Unsafe abortions are a significant concern, especially in developing regions where access to safe abortion services is limited. The majority of the unsafe abortions occur in developing countries, with more than half in Asia and a significant number in Africa and Latin America.

Recent statistics on terminal abortions in Africa reveal some concerning trends. According to Kassa (2024), Sub-Saharan Africa has the highest rate of abortion-related deaths in the

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world, with 185 maternal deaths per 100,000 abortions. The study analyzed data from six countries: Kenya, Tanzania, Ethiopia, Burundi, Nigeria, and Rwanda (Kassa et al., 2024). 6.3% of women aged 15-29 reported pregnancy termination. The prevalence rate was highest in Tanzania (8.8%) and lowest in Ethiopia (4%). Women with no education had significantly higher odds of pregnancy termination compared to those with higher education (Kassa et al., 2024).

Recent statistics on terminal abortions in Uganda reveal some concerning trends. Abortion-related deaths increased from 5% to 8% between 2018/19 and 2019/20. Most of the deaths associated with abortion complications occurred among 10-24-year-old mothers. Recent statistics on terminal abortions in Kampala and Wakiso highlight some troubling trends. Abortion is highly restricted in Uganda, leading many women to resort to unsafe practices. This has resulted in a significant number of abortion-related deaths, particularly among young women aged 10-24 (New Vision, 2020). In Kampala, the restrictive abortion laws have led to a rise in unsafe abortions, with many women facing severe health risks and even death. The situation is similar in Wakiso, where initiatives like the SAFE Initiative are working to improve reproductive health outcomes by providing free, accessible, and stigma-free services (FMP, 2024). These statistics underscore the urgent need for improved access to safe reproductive health services and comprehensive sexual education in these regions. Therefore, there is a need to determine the factors associated with increased abortions among young adults aged 18-25 years at Kajjansi Health Centre IV.

METHODOLOGY

Study Design

A cross-sectional design employing a quantitative method of data collection was used because data collected was used at one point in time, allowing the explanation of factors contributing to increased terminal abortions among young adults aged 18 to 25 years of age, as well as enabling data collection from a random sample.

Study Setting

Kajjansi Health Centre IV is located in Kajjansi C cell, Kitende parish, Kajjansi Town Council, in Wakiso district. It is located in a semi-urban area, where most people are engaged in small-scale business, while others are employed as professionals in several schools, Uganda Clays Factory, and the tea and flower farms in Nakigalala.

The health facility is linked to the main Entebbe highway by a murram road from Kajjansi health Centre, a distance of less than one km.

The catchment area consists of four parishes, which include Bweya, Kitende, Namulanda, and Wamala.

Study Population

Young female adults aged 18 to 25 years who receive their medical care at Kajjansi Health Centre IV in Wakiso District.

Determination of the Sample Size

Kish Leslie (1965) calculated the study sample size using a statistical formula

$$n = \frac{z2\ p\ (1-p)}{d2}$$

Where n is the sample size,

Z is a constant confidence level (e.g., 95%), corresponding to 1.96

P is the estimated proportion of an attribute that is present in the population (8%)

In addition, d is the desired level of 5%.

Z=1.96

P= 8% = 0.08

And d =5% = 0.05

$$n = \frac{Z2p\ (1-p)}{d2}$$

$$n = \frac{1.962x\ 0.08(1-0.08)}{0.052}$$

$$n = \frac{3.8416x\ 0.08(0.92)}{0.0025}$$

$$n = \frac{3.841\ x\ 0.0736}{0.0025}$$

$$n = \frac{0.2826976}{0.0025}$$

n = 113.07904

n = 113.

Therefore, 113 respondents were determined to participate in the study.

The 8%, which is the population, is the attribute of the abortion rate in Kampala.

Sampling Procedure

A simple random sampling was used to collect quantitative data. Young adults aged 18 to 25 years who had consented to be part of the study were selected, and a questionnaire was

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given to them and guided by the research assistants to fill out and answer the questionnaire.

Inclusion criteria

The study considered young adults aged 18 to 25 years during the study period, who gave their consent to take part in the study.

Exclusion criteria

The study did not consider those who were too sick to talk or write, or those who did not consent to take part in the study.

Study variables

Dependent variables

Increased terminal abortions among young adults aged 18 to 25 years.

Independent variables

The independent variables of this study are marital status, Educational level, and Economic status.

Data Collection Method and Tools

Data was collected using a questionnaire method whereby respondents were given papers with options to select from based on what they thought was correct. This was done using a standardized semi-structured researcher-administered questionnaire, which was developed based on the study objectives and literature reviewed in the study.

Data collection procedure

Data was collected using the questionnaire technique. The questionnaire technique was used because the study was concerned with variables that can be easily identified and determined.

Data Quality Control

The quality of the research was maintained by ensuring the validity and reliability of the research instruments. In order to ensure the validity of the data, the researcher gave questionnaires to experienced people who are knowledgeable in the area of study. These people were requested to independently evaluate each item constructed with respect to its relevance to the objective, after which corrections and adjustments were made. The reliability was ensured by providing clear operational definitions of the variables under study, and then, after data collection, reliability analysis was done, and the findings for each of the variables were realized, where they were in line with the study objectives.

Data Management

The obtained questionnaires from the field were securely stored under lock and key to ensure data protection. Each questionnaire was thoroughly inspected for completeness and consistency. Questionnaires with a response rate below 90% were excluded from the final dataset. Additionally, daily cross-checking of collected questionnaires was conducted throughout the entire data collection period to verify completeness and address any missing information.

Data analysis and presentation

The collected data underwent a structured analysis process, ensuring that each component has a specific plan:
The raw data were first manually arranged using tally sheets to facilitate the grouping of similar responses.
This initial organization step ensured clarity in identifying patterns and trends.

Descriptive Analysis

The data was then entered into Excel software for preliminary statistical analysis.
Frequencies and percentages were calculated to summarize key findings.
Results were presented in frequency distribution tables, graphs, and pie charts, each accompanied by brief explanations highlighting the significant patterns observed.

Bivariate Analysis

To explore relationships between variables, a bivariate analysis was conducted.
Statistical techniques such as cross-tabulation and correlation analysis were applied to determine associations between different factors under investigation.
Findings were displayed using comparative graphs and summary tables to illustrate the nature and strength of relationships.

Ethical Consideration

On approval by the Mildmay research committee, written permission to the Research and Ethics Committee was obtained so that the study protocol could be reviewed before the data collection.

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Consent of the participants was sought with an informed written consent before the study was conducted.
A full explanation of the research procedures was given to the participants. Consent forms were used to seek written consent before interviewing.
The information given was kept confidential. The names of the participants were not included in the report.
The participation was voluntary, and one was free to withdraw from the research at any time without any punishment or loss of benefit.

RESULTS

Response rate

To ensure the reliability and validity, questionnaires were administered to 114 respondents, resulting in a 100.9% response rate of the 115 respondents who participated; therefore, the results are valid and reliable.

Table 1: Shows the response rate.

Instrument	Distributed/to be conducted	Conducted	Response rate
Questionnaire	114	115	100.9

Table 2: Background information of the respondents

ITEM	CATEGORY	f	%
Marital status	Single	51	44.7
	Married	23	20.2
	Divorced	11	9.6
	Widowed	9	7.9
	Separated	20	17.6
Length in marital status	< 1 year	23	20.2
	1-5 years	65	57.0
	> 5 years	26	22.8
Influenced by marital status	Yes	68	59.6
	No	32	28.1
Educational level	No formal Educational	5	4.4
	Primary Education	28	24.6
	Secondary Education	34	29.8
	Vocational training	17	14.9
	Higher Education	29	25.4
Education impact	Yes	80	70.2
	No	28	24.6
	Not Sure	6	5.3
Reproductive Education	Yes	97	85.1
	No	17	14.9
Confidence in abortion	Very Confident	11	9.6
	Somewhat Confident	86	75.4
	Not Confident	17	14.9
Economic Status	Employed Full-Time	16	14.0
	Employed Half-Time	17	14.9
	Self Employed	21	18.4
	Unemployed	22	19.3
	Student	28	24.6
	Homemaker	10	8.8

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Household income	Low Income	85	74.6
	Middle Income	23	20.2
	High Income	6	5.3
Effect of Economic Status	Yes	55	48.2
	No	44	38.6
	Not Sure	15	13.2
Decision on Abortion	Yes	86	75.4
	No	28	24.6
Access to Safe Abortion	Very Accessible	33	28.9
	Moderately Accessible	66	57.9
	Not Accessible	15	13.2

Source: Primary data (2025).

Findings show that the 51 respondents who are the majority (45%) are single compared to 8% who are divorced, which indicates that more single people carry out an abortion compared to the divorced or those who were once married.
The findings revealed that the majority (29.8%) of the young adults have attained secondary education compared to the 4.4% with no formal Education, indicating that education plays a significant role in abortion; those who have formal education carry out more abortions compared to those with no formal education.
Findings in Figure 3 show that abortion is more in young women working full-time, with 25% compared to homemakers, with 9%.

Comparing the education level with confidence in abortion

Visual analysis of how participants' education levels relate to their confidence in making abortion-related decisions. A stacked bar chart was used to illustrate the distribution of confidence levels—categorized as Very Confident, Somewhat Confident, and Not Confident—across two education groups: Higher Education (vocational and tertiary) and Lower Education (no formal, primary, and secondary).

Chart Description

The stacked bar chart consists of two vertical bars representing the two education categories. Each bar is segmented into three colored sections corresponding to the confidence levels:

Very Confident (Score = 3)
Somewhat Confident (Score = 2)
Not Confident (Score = 1)
Higher Education Group (n = 46)
Very Confident: 4 participants (≈ 8.7%)
Somewhat Confident: 35 participants (≈ 76.1%)
Not Confident: 7 participants (≈ 15.2%)
Lower Education Group (n = 67)
Very Confident: 6 participants (≈ 9.0%)
Somewhat Confident: 50 participants (≈ 74.6%)
Not Confident: 10 participants (≈ 14.9%)

Interpretation

The chart reveals that "Somewhat Confident" is the dominant category in both education groups, accounting for over 74% of responses. The proportion of participants who reported being "Very Confident" is slightly higher among those with higher education (8.7%) compared to those with lower education (9.0%), though the difference is marginal.
A preliminary t-test comparing the mean confidence scores between the two groups yielded:
Mean score (Higher Education): 1.93
Mean score (Lower Education): 1.91
Difference: 0.02 (not statistically significant)
This suggests that education level does not have a strong or statistically significant influence on confidence in abortion decision-making within this sample.
While education is often assumed to enhance decision-making confidence, the findings here indicate that other factors—such as reproductive education exposure, economic status, or access to safe abortion services—may play a more decisive role. This insight is critical for designing targeted interventions that go beyond formal education and focus on comprehensive reproductive health literacy.
The majority of the respondents were single (44.7%), followed by separated (17.5%) and married (20.2%). This

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suggests that unstable or non-traditional relationships may be a contributing factor to abortion decisions. Most had been in their current marital status for 1-5 years (57%), indicating transitional phases that may influence reproductive choices. 56.6% reported that their marital status influenced their decision to abort.

Most respondents had a secondary education (29.8%) or higher education (25.4%), with only 4.4% lacking formal education; this reflects a relatively educated population. 70.2% believed education influenced their decision, suggesting that awareness and knowledge play a crucial role. A strong 85.1% had received reproductive education, yet abortion rates remain high, indicating possible gaps in practical application or service access.

The largest groups were students (24.6%), unemployed (19.3%), and self-employed (18.4%). This implies that economic instability is prevalent among respondents. 74.6% reported low income, 48.2% acknowledged that their economic status influenced their decision, while 38.6% said it did not.

DISCUSSION

Marital status and its effect on abortion among young adults aged 18-25 years.

The majority of the respondents were single (44.7%), followed by separated (17.5%) and married (20.2%). This suggests that unstable or non-traditional relationships may be a contributing factor to abortion decisions. Most had been in their current marital status for 1-5 years (57%), indicating transitional phases that may influence reproductive choices. 56.6% reported that their marital status influenced their decision to abort.

Educational level and its effect on abortion among young adults aged 18-25 years

Most respondents had a secondary education (29.8%) or higher education (25.4%), with only 4.4% lacking formal education; these reflect a relatively educated population. 70.2% believed education influenced their decision, suggesting that awareness and knowledge play a crucial role. A strong 85.1% had received reproductive education, yet abortion rates remain high, indicating possible gaps in practical application or service access.

Economic status and its effect on abortion among young adults aged 18-25 years.

The largest groups were students (24.6%), unemployed (19.3%), and self-employed (18.4%). This implies that economic instability is prevalent among respondents. 74.6% reported low income, 48.2% acknowledged that their economic status influenced their decision, while 38.6% said it did not.

Conclusion

Marital instability is a key driver; the predominance of single and separated respondents, coupled with their acknowledgement that marital status influenced abortion decisions, suggests that unstable relationships significantly contribute to abortion prevalence.

Education as a double-aged factor, while most respondents had received reproductive education, the high abortion rates imply that knowledge alone is insufficient without access to supportive services and practical guidance.

The high proportion of unemployed and low-income respondents underscores the role of financial insecurity in reproductive decision-making, often pushing young adults towards abortion due to the inability to support the child.

Recommendation

Strengthen comprehensive sexual and reproductive health education, with decision-making skills, emotional support, and practical access to services, and tailor content to reflect local cultural and relational dynamics.

Expand confidential health services, non-judgmental spaces within health facilities where young adults can access counselling and contraception.

Engage men in reproductive health dialogues to enhance male participation and improve shared responsibility to reduce coercive decisions.

Further research areas

Psychosocial impact of abortion decisions to explore the emotional and psychological consequences of abortion among young adults.

Role of cultural and religious beliefs and their influence on abortion rates among young adults.

Effectiveness of reproductive education programs, assess the actual behavioral impact of existing reproductive education curricula, and identify gaps in content and delivery.

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List of abbreviations
VODA- Volunteer for Development Assistance
USAID- United States Agency for International Development.
SAFE- Supporting Access to Justice, Fostering Peace and Equity.
SAAF- Safe Abortion Action Fund
SRHR-Sexual and Reproductive Health
MOH- Ministry of Health
WHO- World Health Organization

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The study was not funded.

Conflict of interest
The author declares no conflict of interest.

Author contributions
MN- Study developer and Data collector.
GK- Supervised the Study.
JFN-Supervised the study.
EO-Analyzed the data.
EA-Data entry.

Data availability
Data is available upon request.

Informed consent
There was full disclosure; full comprehension, and respondents voluntarily consented to participate in the study.

Author biography
Mercy Nafungo is a student at Uganda Christian University, pursuing her Bachelor's of Science in Human Nutrition and Clinical Dietetics.
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