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Abortion as agentic action: reproductive agency among young women seeking post-abortion care in Uganda

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ABSTRACT

Unsafe abortion in Africa continues to be a major contributor to the global maternal mortality which affects young women in particular. In Uganda, where abortion is legally restricted and stigmatised, unsafe abortion is a major public health issue. We explored reproductive agency in relation to unsafe abortion among young women seeking post-abortion care. Through in-depth interviews we found that reproductive agency was constrained by gender norms and power imbalances and strongly influenced by stigma. Lack of resources and the need for secrecy resulted in harmful abortion practices and delayed care-seeking. Women did not claim ownership of the abortion decision, but the underlying meaning in the narratives positioned abortion as an agentic action aiming to regain control over one's body and future. Women's experiences shaped contraceptive intentions and discourse, creating a window of opportunity that was often missed. This study provides unique insight into how young women negotiate and enact reproductive agency in Uganda. Health systems need to strengthen their efforts to meet young women's sexual and reproductive health needs and protect their rights. Enabling young women's agency through access to safe abortion and contraception is paramount.

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Gender norms; reproductive agency; Uganda; unsafe abortion; young women

Introduction

Although entirely preventable, unsafe abortion continues to be a major contributor to the global maternal mortality, exerting a heavy toll on women's lives (Faundes and Shah 2015). Young women (aged 15–24) in Africa are especially vulnerable, mirrored by the fact that 50% of all unsafe abortions in the region occur among women in this age group (Shah and

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Åhman 2012). The World Health Organisation defines unsafe abortions as 'those performed either by individuals lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both', while also emphasising the influence of the social and legal context on abortion safety (Ganatra et al. 2014). The right to sexual and reproductive health is inseparable from the broader right to health and entails the ability to make free and responsible decisions over matters concerning one's body (CESCR 2016). In Africa, economic inequality and patriarchal structures sculpt and reinforce gendered power imbalances and traditional gender norms, thereby compromising women's decision-making power and contributing to the issue of unsafe abortion (Braam and Hessini 2004). The decision to have an abortion is influenced by one's social, economic and ideological context (Kumar, Hessini, and Mitchell 2009). In Uganda, where abortion is legally restricted and highly stigmatised (Hussain 2013), most abortions are thought to be unsafe (Sedgh et al. 2012). However, little is known about decision-making or the conditions under which abortions occur in this context. Studies that encompass women's own accounts of their abortion experiences are lacking in particular. The present study explores reproductive agency in relation to unsafe abortion among young women seeking post-abortion care in Uganda.

The context

Uganda has one of the world's youngest populations; 78% of the population is 30 years old or younger. The fertility rate remains high (6.2), and contraceptive use is low, especially among young people (UBOS 2012). Barriers to contraceptive use among young people include contraception misconceptions, gendered power imbalances, socio-cultural expectations and health service barriers (Nalwadda et al. 2011). Moreover, poverty and rural living compound women's vulnerability to unintended pregnancy (Hussain 2013). While fertility is highly valued in Uganda, the context and timing of a pregnancy is equally important (Atuyambe et al. 2005; Kaye 2006), and pregnant young women risk disrupted education, stigmatisation and physical and physiological abuse (Atuyambe et al. 2005). Abortion in Uganda is legally permitted to save the life and health of a pregnant woman. However, the penal code is unclear and not harmonised with the constitution and the reproductive health policy, resulting in ambiguous understanding of the law and what it permits. Often the law is interpreted as completely prohibitive (CRR 2012). Pervasive abortion stigma reflected in general discourse in media reporting (Larsson et al. 2015) and legal restrictions on induced abortion limit access to good quality care and discourage women from seeking post-abortion care (Hussain 2013). Self-inducing abortions with herbs or solid objects are believed to be more common among poor and rural women, while non-poor urban women are more likely to turn to trained abortion providers (Singh et al. 2006).

Opposition to abortion is partly rooted in the traditional views on gender and the dominant religious influence in Ugandan society (Kabagenyi et al. 2014; Larsson et al. 2015; Moore, Jagwe-Wadda, and Bankole 2011). Conceptions of femininity are closely attached to parenthood in Uganda (Nyanzi, Pool, and Kinsman 2001); hence, abortion challenges the ideal of 'real womanhood' and a woman's fundamental role of bearing children (Petchesky 1985). Ugandan men's attitudes towards abortion and contraception have been found to mainly reflect traditional social norms and values (Kabagenyi et al. 2014; Moore, Jagwe-Wadda, and Bankole 2011). Because men often have greater decision-making power and financial resources, their attitudes can significantly influence women's access to sexual and

reproductive health care (Kaye 2006; Moore, Jagwe-Wadda, and Bankole 2011). By exploring reproductive agency in relation to unsafe abortion, we hope to gain a better understanding of how the social environment shapes young women's reproductive decision-making and actions, as well as determine the circumstances under which abortion is conducted and post-abortion care is sought. This information can provide insights into how to better cater to young women's sexual and reproductive health needs and aid in the prevention of abortion morbidity and mortality in Uganda.

Theoretical considerations

According to Ortner (2006), agency denotes the capacity for action and the ability to influence events and maintain some control over one's life. We used Ortner's work on agency to conceptualise and discuss our findings concerning young women's experiences of unintended pregnancy and unsafe abortion. The relationship between agency and power is often witnessed in gender relations, which are the social relations that arise in and around the reproductive arena (Connell and Pearse 2015). Furthermore, gender, age, ethnicity, class and their intersections influence women's capacities to exercise their sexual and reproductive rights (Goicolea 2010; Petchesky 1985). Ortner (2006) concedes that while we are not thoroughly determined beings, we are also not free agents who can act outside the social system we inhabit. Moreover, she notes that neither individuals nor social forces have precedence.

In her work, Ortner (2006) describes two inter-related types of agency: agency for projects and agency for power. Agency for projects concerns intentionality and the pursuit of 'projects' that are always culturally constituted. Intentionality encompasses all the ways in which action is cognitively and emotionally pointed towards some purpose. Agency for power is about power and acting within relationships of social inequity, asymmetry and force. Despite power asymmetry, subordinate agents always have some capacity to influence events, indicating that all power relations are unstable. Ortner (2006) emphasises that while all individuals 'have' agency, agency cannot be equated with either free will or resistance; it is always socially embedded and shaped within different power regimes. Agents are constantly engaging with their context, and through their actions social formations of power are produced and reproduced (Ortner 2006).

Materials and methods

Study setting

The study was conducted in the capital city of Kampala, located in Uganda's central region. The centre district of Kampala is mainly industrialised, while the suburbs are dominated by small-scale industrial and agricultural production. In the central region, the Baganda are the main ethnic group, and Luganda is the pervasive local language, although English remains the official language (Fountain Publisher 2007). Mulago Hospital, from where the study participants were recruited, is a public national referral hospital. While it receives patients from all over the country, most of its patients are from the central region. The hospital has an emergency gynaecology ward in which post-abortion care is provided. This study site was deemed suitable for recruitment due to the diversity of patients who seek care at this hospital and its high caseload of post-abortion care patients.

Table 1. Socio-demographic background and reproductive history of respondents ($n=17$)

	N		N
Age		Parity	
16–18	7	0	13
19–20	6	1	4
21–25	4		
Marital status		No of abortions ^b	
Married	1	1	15
Unmarried	16	2	2
Education ^a		Gestational age (weeks) ^c	
Primary	4	First trimester	10
Secondary	11	Second trimester	6
Missing	2	Unknown	1
Occupation		Abortion method used ^d	
Student	7	Herbs/sticks	4
Formal employment	3	Medication	6
Informal employment	4	Surgery	7
Unemployed	2		
Housewife	1		
Current residence			
Rural	3		
Urban	14		

^aStarted not always completed.

^bIncluding most recent abortion.

^cAt the time of most recent abortion.

^dMost recent abortion.

Study design, participants and data collection

This qualitative study consists of 18 individual in-depth interviews conducted with 17 women between April and August 2013. Women between the ages of 15 and 24 years who were thought to have had an induced abortion were asked to participate. Midwives on the ward helped to identify potential interviewees, who were then approached by the first author (AC), a midwife and a researcher from Sweden. Only women who reported their most recent abortion to be induced were included in the study. One of the women was found to be 25 years of age, not 24, as first thought. This respondent was still included due to her proximity in age.

The women were informed about the study's objectives and assured that their confidentiality would be safeguarded. Contact information was exchanged with women who showed interest in participating. All but two of the interviews were conducted on a separate occasion from when initial contact had been made. One interview was conducted at the interviewee's home, and the rest were conducted in a private room at the hospital. One woman was interviewed twice in order to clarify some of the viewpoints that emerged in her first interview. The socio-demographic backgrounds of the study participants are summarised in Table 1. AC conducted all the interviews. The remainder of the research team consisted of researchers from Sweden (EF and MKL) and from Uganda (GN), all of whom had had experience conducting both quantitative and qualitative research in this context.

A semi-structured interview guide with open-ended questions was used to explore the women's experiences of unintended pregnancy and abortion, their decision-making in relation to contraception, abortion and care-seeking, and the roles played by their partners, friends and family. The research team developed the data collection tool, which was

pilot-tested prior to data collection. The interviews were conducted in English when the interviewees' English language skills were sufficient. Otherwise, the interviews were conducted in Luganda and then translated into English by a Ugandan female research assistant with previous qualitative research experience. Three interviews were conducted in English without the research assistant present. The interviews lasted between 40 and 90 min. Data collection was stopped when no new information was generated.

Data analysis

The interviews were recorded and transcribed verbatim. When necessary, the interviews were translated from Luganda into English during transcription. The research assistant later checked the transcription and translation quality and suggested changes where appropriate. AC conducted the data analysis parallel to data collection, in communication with the research team. Thematic analysis using an inductive approach was chosen because this methodology allows for flexibility and contextual consideration (Braun and Clarke 2006), and, since little is known about the studied topic, data-driven analysis was deemed suitable. The transcribed data were read through several times, organised into topics and then manually coded. The codes were organised into categories and then into themes representing the identified patterns in the data. Data containing both manifest and latent content were extracted for each theme. Throughout the research process, the co-authors discussed the identified themes and their interpretation.

Ethical considerations

Ethical clearance was granted by the Department of Obstetrics and Gynaecology, Faculty of Medicine and Research Committee, Mulago Hospital, and by the Swedish Ethical Review Board (Dnr 2011/1490-31/4). Verbal and written consent was sought and obtained from all respondents. The women were informed that participation was voluntary, that their responses were confidential and that they could end the interview at any time. The interviews were conducted in a private room where conversations could not be overheard. The majority of interviews were conducted on an occasion separate from the first encounter, in order to ensure that participation was truly voluntary. At the end of the interview, the respondents were provided with information about where they could access free contraceptive counselling, and, in cases where an unintended pregnancy was due to rape, the women were provided with contact information for a counselling service offering rape support. In order to protect the identity of the participants, the data were anonymised and stored safely in a password-protected computer.

Findings

The data analysis yielded four themes. The presentation of the themes follows each woman's process, beginning with the circumstances under which she became pregnant, the abortion decision, how intentions turned into action and, finally, the consequences of the abortion experience.

Unintended pregnancy: power imbalances and contraception misconceptions

Power imbalances within the confines of intimate relationships and sexual encounters were apparent in the interviews. Respondents had limited negotiating capacity with regards to contraception and the timing of sexual encounters. A couple of the women reported being attacked and raped, and several women spoke of being forced by their partners into having unprotected sex. In addition, unsafe sex was described as attributed to love and trust, sometimes with a belief that an unintended pregnancy would result in marriage. Some women described situations whereby men used emotional pressure to dissuade condom use. One respondent said:

You can be in a relationship and your boyfriend can say 'no, we have reached the time of enjoying ourselves, and he's like, 'I can't use a condom I don't feel like using a condom. You love me and I love you too so why should we use a condom?' If at all you refuse, the relationship ends. ... If you trust that boyfriend then you do it [have unprotected sex]. (Harriet, 21 years old)

One woman explained that the limited negotiating capacity of young women was a result of economic dependency on male partners, causing power imbalances and impeding reproductive agency. She said:

Economic dependency ... to me actually economic dependency is the biggest challenge. Most of the young women I have interacted with, my peers, at times they tell you, I didn't really want but I had no option and he refused to wear a condom. (Esther, 25 years old)

Couple communication regarding childbearing, sex and contraception was uncommon. The general consensus was that men do not like contraceptives, and reasons cited for this included fear of side-effects and not knowing how to use condoms. The women seemed to accept their partners' wishes and instead of using modern contraceptives they relied on traditional methods, such as safe days or the withdrawal method. Respondents also expressed a fear of side-effects from contraceptives such as cancer, infection and infertility. The latter was perceived to be a particular risk for younger women. One woman stated:

Others say that family planning can destroy your eggs if you are in an early age or if you are not in a late age. If you're still young, then it can destroy your eggs. When you've grown old then you can start injecting or when you already have some children, then you get family planning. (Mercy, 19 years old)

Avoiding stigma and regaining control: implications for agency

Challenging social circumstances were given as the reason why the respondents and other young women in Uganda resort to abortion. Abortion was sometimes described as an immoral, unacceptable, unwanted act, and yet the only option available. It was simultaneously portrayed as a moral responsibility, given a woman's personal circumstances. Abortion enabled the respondents to continue their education or employment and, thereby, enhance their possibilities of future social advancement and economic independence. By having a clandestine abortion, they could avoid social stigma and negative social sanctions while appearing to adhere to established gender norms. Secrecy was also important, as it enabled agency by allowing the women to maintain decision-making power.

Anticipated negative reactions and sanctions by parents, such as social exclusion, shame, abandonment and physical violence, were mentioned as important elements in the decision

to abort and maintaining secrecy. One woman explained why she kept her pregnancy a secret from her family:

Secret! It might put me in trouble. If at all my brother knows it, he might tell my parents and they start quarrelling. Some people can chase you out from home. There are some parents who are very tough. ... If you're married, then its better but if at all you're still a young girl at home, to get pregnant and you're not married, it's bad. It is not good in our culture. (Doreen, 19 years old)

Stigma attached to unintended pregnancy and abortion would extend to the woman's family; her parents would be labelled as irresponsible and inadequate, and their children would be seen as disrespectful. The respondents described education as being very important and highly valued by society; therefore, discontinuing education was also a source of stigma and was viewed as a failure in the community. One respondent said:

Yeah, they can say that, 'they were providing her school fees but now you see she never completed. Why didn't they eat their money and get satisfied? Why didn't they even buy clothes to wear? They were providing money for her school fees but see now she is pregnant', they can over-talk actually. ... Mostly it shames the family. When I get pregnant, I shame my parents and my family plus my young sister, I give them a bad image. (Justine, 19 years old)

Several women described paternal denial and a lack of support and interest from partners as the main determinant in the abortion decision. Respondents relayed how paternal denial was unacceptable in Ugandan society, which would label them as prostitutes and immoral if they continued the pregnancy. Furthermore, in the future they might find it difficult to marry. One respondent stated:

Yes, it's shameful because, they will ask for the child's father and you do not know what to say. Now there you lose respect from everyone, some would think that you are a prostitute selling yourself. (Florence, 19 years old).

The same labels would be attached to women who abort and thus provided further reason to maintain secrecy:

Here in Uganda, it's very bad. If they hear about you that you aborted, you are just like that. It's like they take you as someone who is a prostitute, yeah. You don't give birth, you who just abort. Yeah, they don't respect you (Mercy, 19 years old).

Paternal denial could also result in economic hardship. Without anyone to help provide for the child, women resorted to abortion:

Being pregnant and taking a baby to your mother, no! Like me, I got pregnant when I was not ready for it ... and the man was not ready, we talked and agreed to abort because taking a child to your parent when they have their own work to do is not easy. ... If the man says he doesn't want the child, then what he says is what you do. (Norah, 18 years old)

However, a couple of the respondents had terminated their pregnancy against their partners' will; their decision being driven by a combination of fear of stigma and desire for education and economic independence. The importance of financial stability before becoming a parent and having adequate financial capacity to provide for one's children were emphasised by some respondents, who said that anything else would be frowned upon in today's society. Birth spacing and limiting family size by using contraception were required for financial solvency, and abortion was portrayed as an act of responsibility. One respondent described a discrepancy between the older generation's view on childbearing and their own. The older generation still placed high value on giving birth to many children, while today's youth aimed for smaller families. She noted her reasoning after becoming pregnant again shortly after giving birth to her first child:

Because our baby is the first born yet we wanted him to be in a good life, to go in good schools when we are working so that we can build house. I thought of a lot of things at that time because I actually saw that I was standing in the future of my baby because that was not our target, even how Uganda is standing today to have a baby yet I had another baby, I said No. (Rashida, 21 years old)

Risk-awareness and risk-taking while maintaining secrecy

Secrecy was critical to reducing the risk of exposure and stigmatisation. However, maintaining secrecy came at a cost, as it indirectly increased health risks. Tactics to avoid disclosure included seeking care from private rather than public providers, seeking care after sundown, only confiding in a few carefully selected individuals or in no one, self-inducing abortions and withholding the truth in encounters with health care providers. One respondent said:

I think it's maybe because of stupidity that I feared to tell the truth because if I had said the truth they would have brought me direct to Mulago (hospital), but because I feared and didn't say the truth that's why I went to the pharmacies and spent a lot of money and I was not healed. (Rashida, 21 years old)

The need for secrecy meant that most women went through this experience alone, some spending weeks or even months gathering enough money for an abortion. The unaffordability of abortion and post-abortion care services, not recognising pregnancy symptoms and waiting for partners to take responsibility contributed to delayed care-seeking and second-trimester abortions. When seeking post-abortion care at private facilities, women were required to pay once again; eventually, they ended up seeking health care from a public facility. When experiencing complications, several of the respondents used herbs to treat excessive bleeding, thus delaying appropriate treatment. One respondent said:

If I had money, I would have got treatment early enough not to let these things rot inside me. But all this happened because I didn't have money. ... I delayed because I did not have money to bring me here to the hospital. Also, I thought this local herb called *kamunye* would work for me but whenever I would take it, a lot of blood would come out smelling badly, which made me come here in the hospital for a check-up. I did not know that something's remained inside. (Florence, 19 years old)

The respondents described several risks associated with abortion: health risks, being exposed to family members and society, and facing possible legal repercussions. One woman described the fear she felt when seeking post-abortion care:

Yes, I thought about it. If they know about me, they will take me to prison, 'cause here they can imprison you and they can imprison even that one in the clinic, the doctor who operated on me. ... So they can imprison me because that is a murder. That's bad. It's like you've killed someone. But because you don't have anything to do, that's why we abort. Yeah, it's bad. (Mercy, 19 years old)

However, fear of legal repercussions was not a major concern for most of the respondents, who explained that their fear of being socially exposed and fear of dying were much stronger. The respondents displayed a perception of abortion as being a health risk, and they mentioned death and infertility as possible consequences. Many of the respondents expressed an immense fear of dying, but that fear was not a determinant in their abortion decision. One respondent said:

Yes, I had heard about it [health risks] before and I knew that when you take it, it can kill you. But because I had nothing to do at that time, I had nowhere to stay, yet I had a child whom I

have to care about, I decided to take it. If am to die, I die. ... I had surrendered my life to die. (Harriet, 21 years old)

In contrast, another respondent stated:

I did not fear anything because I was really fed up and tired. So, I did not fear. (Mary, 20 years old)

A few respondents elaborated on health risks in relation to abortion and the factors that affected their safety, which guided their care-seeking behaviour. Some clinics were considered to be safe due to their willingness to provide abortion services or because the clinic's location meant that the abortion would likely remain a secret. The respondents noted that if a woman went to a doctor or to a 'nice clinic' instead of self-inducing with herbs, or if the abortion was done in early pregnancy, the procedure tended to be safe.

The abortion experience shaping discourse and contraceptive intentions

The abortion experience shaped respondents' discourse and intentions regarding post-abortion contraceptive use. When discussing post-abortion contraceptives and their thoughts on future childbearing, the respondents expressed a wish to prevent pregnancy and to obtain information on contraceptive methods. Most of the respondents intended to use contraceptives in the future, regardless of their partner's wishes. The consequences of unintended pregnancy and abortion were described as affecting only women's lives and bodies; therefore, the choice of using contraception was rightfully theirs to make:

Yeah, if at all he can't agree with me then he can try another level to get someone who he can try that with because I am the one who suffered a lot, not he, but it's me, and I am the one who knows my life. I am the one who felt a lot of pain. (Doreen, 19 years old)

For me, I have to decide for myself. If I want to use [contraception], I have to use it for myself because if I get problem, it's me who suffers alone because some of these men know how to run. You tell them that I am pregnant, they begin denying saying that 'it's not mine, it's your other boyfriends', ey! ... and he runs away from you. So if I want to use it I do it for myself because I have to die for my own self. If I want to use it I have to use it by force. (Justine, 19 years old)

Only one respondent had received post-abortion contraceptive counselling before being discharged. Reasons for not receiving contraceptive counselling included the staff being too busy, women seeking care late in the evening, or the respondents themselves not having time or not feeling well enough to receive any counselling.

Discussions

Young women's abortion experiences in Uganda have not previously been explored and delineated, which makes this study unique. Our findings reveal how gender norms and power imbalances create vulnerability and constrain women's decision-making power in relation to consensual sex, contraception and abortion. Within this context of power asymmetry, reproductive decisions were made by navigating gender norms and expectations, morals, fear of stigma, health risks and the desire for education and social mobility. The discussion below elaborates on how young women negotiated reproductive agency, how that agency was enacted and its consequences.

Previous studies in Uganda have revealed young women's limited negotiating capacity in relation to contraceptive use and the prevalence of coerced sex (Muhanguzi 2011; Råssjö

and Kiwanuka 2010). Shifting sexual norms among young people have been reported whereby traditional gender ideals of female chastity and submissiveness become intertwined with modern ideals of sexual freedom and experience, while contraceptive use remains low (Nyanzi, Pool, and Kinsman 2001). The sexual landscape has been described as fraught with homophobia, misogyny, male domination, sexual abuse and control of female sexuality (Muhanguzi 2011). Harmful sexual norms, pervasive power imbalances and limited access to sexual and reproductive health care impair agency and thereby contribute to the issue of unsafe abortion in this context. Although information on young women's sexual vulnerability in Uganda is not completely new, our findings contribute to a better understanding of these women's pathways to unsafe abortion. They also highlight the continuing need for interventions that address sexual norms and contraception misconceptions and underscore the importance of consent in every sexual encounter.

Within relations of power and inequality, agency has been described as complex and contradictory (Ahearn 2001; Ortner 2006); we also see this in our study. In contrast to the findings of a study among post-abortion care patients in Ghana (Oduro and Otsin 2014), respondents in this study did not claim ownership of their bodies and the abortion decision. Instead, they described abortion as an immoral act yet the only choice they had, thereby reflecting powerlessness and views consistent with the discourse on abortion in this context (Larsson et al. 2015). Thus, abortion was portrayed as an act of capitulation to personal and social circumstances. In this sense, abortion can be viewed as a form of acceptance of pervasive power structures. It is clear that agency was deeply enmeshed in unequal power relations, creating an impetus for clandestine and unsafe abortion. However, as we have seen here, there were a myriad push-and-pull factors at play within the specific life-trajectory and the wider context. Although the abortion decision was portrayed as a non-choice, the underlying meaning in the narratives simultaneously positioned abortion as an agentic action aimed at regaining control over one's body and future. Despite power asymmetry, women found leeway for action, supporting Ortner's (2006) view that agency is conditioned by the social system but is not necessarily determined by it. Our findings are also in line with the thinking that agentic action can be used to regain power (Maxwell and Aggleton 2010). In this light, we argue that abortion represents a vital form of female empowerment and a prerequisite for female emancipation in Uganda. From our perspective, the women in our study can be viewed as victims of their social context and personal circumstances and, simultaneously, as agents acting to regain control over their sexual and reproductive health and lives.

Applying the two dimensions of agency described by Ortner (2006) to our findings, the act of abortion can be seen as both agency for power and agency for projects: the abortion is enacted within a context of power asymmetry which conditions agency and is aimed at regaining one's prospects of attaining previously established (culturally constituted) goals of education and social mobility. Agency is negotiated within the web of relations that make up the individual's social world (Ortner 2006). In our study, the social world in which agency was negotiated and enacted was fraught with power imbalances and contradicting norms and expectations; thus, our respondents may be viewed as 'having little' agency. Nevertheless, through their actions our respondents influenced their sexual and reproductive health and regained some control over their lives, and thereby they are also part of changing history and the world they engage with (Ortner 2006).

Earlier studies from settings in Africa (Rossier 2007; Schwandt et al. 2013) have revealed how prospects of economic support and a socially accepted pregnancy may determine the abortion decision; this was also seen in our study. Our findings illustrate the contradictory pressures that gender norms impose on women and the power embedded in and inflicted by stigma. Perceived stigma refers to the extent to which a person believes that others will devalue or discriminate against them because of their behaviour (Link and Phelan 2001). The way women perceived stigma and the consequences of their behaviour permeated the abortion narratives in our study and generated a push for abortion, albeit with an awareness of risk. The transgression of established social norms created a form of 'double stigma' whereby, no matter what the women did, they expected to experience stigma. In contrast, in Kenya, Izugbara, Otsola, and Ezeh (2009) found that while protection against shame was cited as a reason for abortion, the negative socio-economic consequences of mistimed child-bearing weighed heavier in the abortion decision. In our study, some respondents described abortion as an act of moral responsibility when facing economic hardship, a narrative that is not unique for sub-Saharan Africa (Whittaker 2002). These findings illustrate how the responsibility to prevent mistimed childbearing and the related stigma and its consequences are highly gendered and influence agency. They also mirror what we interpret as an on-going transition from traditional fertility ideals to more modern ideals of limiting the number of children in favour of education and economic security. Still, without any change in social norms and without access to sexual and reproductive health care, women will continue to risk their lives, both due to and in spite of economic constraints and fear of moral condemnation.

Similarly to preceding studies (Schwandt et al. 2013; Shellenberg et al. 2011) secrecy was an important tactic that enabled agentic action while avoiding stigma and appearing to adhere to established social norms. However, our study revealed the health implications of maintaining secrecy as a lack of resources, coupled with the need to avoid exposure, resulted in delayed care-seeking. To our knowledge, the use of herbs to treat abortion complications has not been previously reported. Yet this practice, the ultimate purpose of which was to avoid seeking care from formal health services, seemed common knowledge among the respondents. Several women in our study reported using medication, presumably misoprostol, to induce abortion. As medical abortion becomes more widely available, abortion mortality and severe morbidity seem to decline (Sedgh et al. 2016). Still, no matter the abortifacient, post-abortion care needs to be provided in a timely manner in order to save lives and prevent morbidity (Faúndes 2012). In Kenya, delayed care-seeking for abortion complications has been associated with lower age and lower education level (Mutua et al. 2015) and with increased severity of complications (Ziraba et al. 2015); these findings are likely to be generalisable to the Ugandan setting. Thus, our findings expose young women's risk for morbidity and mortality due to abortion and underscore the need for access to affordable post-abortion care and interventions to reduce stigma.

Without the provision of post-abortion contraceptive counselling, there is a risk of repeat unsafe abortion; thus, the preventive component of post-abortion care is one of its main strengths. However, post-abortion care providers in Uganda lack skills and resources as well as support from the health system to successfully provide services to young people (Paul et al. 2016). Not offering post-abortion contraceptive counselling is a missed opportunity for prevention and a major failure of the health care system. We found that the experience of unintended pregnancy and unsafe abortion shaped future contraceptive intentions and

fostered a language in which women claimed ownership of their sexual and reproductive health decisions, creating a form of resistance to male authority. These findings strengthen the notion of post-abortion contraceptive counselling as an important opportunity (Gemzell-Danielsson and Kallner Kopp 2015). Keeping in mind the instability of power relations (Ortner 2006), this new-found resistance can be viewed as a window of opportunity, which, if taken advantage of, could enable agency and greatly empower women.

Strengths and limitations

Our findings are not necessarily transferrable to all young women who undergo unsafe abortions in Uganda. Efforts were made to ensure that participation was voluntary, rapport was built and bias due to social desirability was reduced. Nevertheless, due to the sensitive nature of this subject, we cannot completely exclude this type of bias, and we recognise that while some responses might be deemed socially acceptable, they do not necessarily reflect a respondent's personal feelings. Although language barriers are a weakness of a cross-cultural study, several efforts were made to overcome them. There are important ethical concerns when interviewing women about an experience that could be perceived as traumatic. Concurrently, the interviews were perhaps the only opportunity the women had to discuss their experiences. We also found that being interviewed by someone from a different context was positive in the sense that the women seemed eager to delineate both their context, in the way they perceive it, and their experiences. Applying Ortner's (2006) conceptualisation of agency to the issue of unsafe abortion helped us better understand the different forces that shape and influence decision-making and action; it also helped us appreciate how young women manage reproductive contingencies within power asymmetry. Reflection on reproductive decision-making and action in terms of agency, rather than autonomy or choice, has the potential to offer a more composite, in-depth understanding of women's capacity to control their sexual and reproductive health and their lives.

Recommendations

The government of Uganda has voiced strong commitment to improving access to contraception as part of a strategy aiming to benefit from the demographic dividend (Uganda Ministry of Health 2014). Yet our findings contribute to the body of evidence (Atuyambe et al. 2015; Nalwadda et al. 2011; Paul et al. 2016) that exposes a major gap between policy and practice and an urgent need for quality, evidence-based, youth friendly sexual and reproductive health services that challenge traditional gender norms and power imbalances and reduce stigma. There are clear evidence-based social and economic benefits to investing in young women's health and wellbeing, including promoting gender equality and women's empowerment (Kuruvilla et al. 2016). Uganda's Gender Policy (2007) proclaims the government's commitment to sexual and reproductive health and rights by putting gender relations at the centre of interventions (Uganda Ministry of GLSD [Gender, Labour and Social Development] 2007). However, if women's rights are to be respected and gender equality achieved, women must have access to quality abortion care, contraception and social support. Ultimately, enabling young women's reproductive agency is about allowing women to reach their full potential so they can not only survive but also thrive and transform their lives.

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