CRIMINALIZATION OF ABORTION AND ACCESS TO POST-ABORTION CARE IN UGANDA

Community experiences and perceptions in Manafwa district

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social justice in health

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ABBREVIATIONS

ANC	Antenatal care
ARDI	African Rural Development Initiative.
CRR	Center for Reproductive Rights
CEHURD	Center for Health, Human Rights and Development
DHO	District health officer
DPC	District police commander
HC	Health center
IUD	Intra-uterine device (method of contraception)
PEP	Post-exposure HIV prophylaxis
PMTCT	Prevention of mother-to-child transmission of HIV
PRA	Participatory reflection and action
SAAF	Safe Abortion Action Fund
STI	Sexually transmitted infection
UBOS	Uganda Bureau of Statistics
UTI	Urinary tract infection
WHO	World Health Organization

EXECUTIVE SUMMARY

Background

Unsafe abortion is one of the leading causes of maternal morbidity and mortality in Uganda. Of the over 6,000 estimated maternal deaths that occur in Uganda every year, about 26% – more than one quarter – are attributed to unsafe abortion[1]. Similarly, an estimated 40% of admissions for emergency obstetric care in Uganda is a result of unsafe abortions.[2] As a result, the health system spends a whopping Ushs 7.5 billion every year to treat complications of unsafe abortion.[3]

The problem of unsafe abortion is a multifaceted one which includes cultural, religious, gender, legal, human rights and public health dimensions.

Uganda's legal and policy framework restricts termination of pregnancy but is accommodative in its provisions as it offers opportunities for increasing access to safe and lawful termination of pregnancy to save the life and health of the expectant mother.

This has been expounded upon by the Ministry of Health which has elaborated such circumstances in the National Policy Guidelines and Service Standards for Sexual Reproductive Health and Rights of 2012.

However, the conflicting interpretation of provisions of the Constitution, Penal Code Act and National Policy Guidelines and Service Standards which do not clearly state the circumstances under which abortion is permitted have created uncertainly among the different stakeholders including women, healthcare providers, law enforcers, judiciary, legislators, and others (CRR, 2012)

Objective

In order to contribute to addressing the public health crisis of unsafe abortions and human rights challenges therein, Centre for Health, Human Rights and Development (CEHURD), working with partners, implemented an action research project which engaged community stakeholders in Manafwa district in Eastern Uganda with the

1 See Submission to the All Party Parliamentary Group on Population, Development and Reproductive Health, U.K., December 8-9 2008 by Hon. Dr Stephen Mallinga and Dr. Anthony Mbonye on Maternal Morbidity and Mortality in Uganda.

2 Mbonye A K et al.: Emergency obstetric care as the priority intervention to reduce maternal mortality in Uganda. *International journal of gynaecology and obstetrics: the official organ of the International Federation of Gynaecology and Obstetrics* 2007, 96:220–5.

3 Vlassoff M et al., The health system cost of post-abortion care in Uganda, Health Policy and Planning, 2012. Available at: http://heapol.oxfordjournals.org/content/early/2012/12/28/heapol.czs133.full.pdf

aim of understanding, documenting community knowledge, attitudes and perceptions on abortion and creating clarity in the understanding of Uganda's legal and policy environment on abortion.

Methods

This action research used participatory approaches to analyze community-level understanding and application of abortion laws in Manafwa district. The project team convened a Participatory Reflection and Action (PRA) session, held community dialogues, interviewed key stakeholders, engaged students and conducted interviews with women and girls who have had some experience with unsafe abortion. Personal interviews were held with health program managers, law enforcers, service providers, civil society, and community representatives.

Results and emerging issues

On stakeholder attitudes and perceptions on abortion;

- Stakeholders participating in this work overall had mixed reactions about the subject of abortion and the circumstances under which it should be allowed. It was clear that the perceptions where highly influenced by religion, customs and the poor understanding of the law.
- Some of the stakeholders believed that abortion is criminal and a miscarriage is not, thus they were of the view that abortion was a police issue.
- Victims of unsafe abortion reported that their decision to terminate their pregnancies was justified by the prevailing circumstances at the time. Majority of students engaged were not as keen to know more about the topic of abortion as they were about preventing unintended pregnancies and HIV.
- Teachers, law enforcers, and health workers analyzed unintended pregnancy and unsafe abortion from a moral perspective. Teachers for instance explained it as a "bad practice" that interrupts a girl's education and is a risk to her life.
- There was an information gap in the kind of sensitization messages that the health providers and the teachers delivered to the adolescent students.

On prevalence of unsafe abortion in Manafwa;

- Responses from the different categories of respondents indicated that unsafe abortion is highly prevalent in Manafwa district. Health centers in the district recorded at least 200 cases of post-abortion complications in 2013 alone.

- Stakeholders reported that the registered cases of post abortion care were a gross understatement of the crisis in the district. This is because so many women do not come to the health facilities for assistance.

- The high number of unsafe abortions was attributed to low use of contraceptives, cultural practices which encouraged newly circumcised men to engage in sex with young women; high prevalence of incest, defilement, gender-based violence, commercial sex work in the district and a fear of the law which is broadly understood to prohibit abortion all together.

- Most respondents within the community reported knowing at least one case of abortion in their community, and knowledge of cases that had ended in death.

On contraceptive uptake and abortion practices;

- Women admitted to using local herbs, cassava sticks, bed springs, metallic objects, an overdose of medication and concoctions to induce abortions.

- Some participants believed that parents and teachers have not provided adequate guidance to girls on options before and after unintended pregnancy.

- Health providers reported that most cases of unsafe abortion are induced by the women themselves; and that these take place within 14 weeks of gestation.

- From the health provider perspective, adolescents' uptake of contraception has been affected by myths and misconceptions, including failure to conceive after use of contraceptives.

- Counseling of family planning clients has not been adequate and some users have not received effective support to overcome side effects.

On health system capacity to provide maternal services;

- The health facilities in the district currently don't have capacity to provide all maternal health services and government is improving maternal and child health services through constructing maternity and general wards for referrals and inpatient care at HC IIIs, this will ultimately improve the health system's capacity to respond to maternal and child health issues.

- The level of emergency preparedness for provision of maternal health services overall were found to be low. The district does not have a referral hospital or functional ambulance; blood transfusion is only available at one health center and referrals are made to Mbale regional referral hospital.

- The district is experiencing a shortage of staff. At the time of this work, the district had only one doctor and limited midwives to respond to the number of expectant mothers.
- Some basic equipment, such as equipment to test blood pressure and hemoglobin levels, could only be found in a few facilities in the district.
- The office of the DHO also reported that medicine supplies were insufficient and irregular.
- Facilities have difficulties meeting utility bills with the limited primary health care (PHC) grants allocated to health centers.

Recommendations

- Communities should be sensitized on the provisions of the law on abortion; opportunities for safe, legal abortion; and their role in advocating for legal reform. Enhance knowledge of the law by health providers and law enforcers.
- There is need to create awareness of family planning and contraception services; promote uptake and utilization amongst the youth as a preventative mechanism against unintended pregnancies.
- Improve the capacity of health facilities (including emergency preparedness) to provide safe, legal abortion and provide post abortion counseling and care.
- Encourage and promote sex education in schools for adolescents such that boys and girls can make informed decisions in sexual relations and avoid unintended pregnancies.
- Speed-up the formulation of service guidelines and standards to provide guidance to health providers in providing care for women with complications from unsafe abortions.
- Advocate for reform of the abortion law to align it with practical realities of the abortion situation in communities, including clarifying circumstances under which a legal abortion may be carried out.
- Building the capacity of service providers in dealing with physiological problems, and in effective counseling for family planning clients.

1. BACKGROUND

1.1 Health system capacity to provide maternal services

Manafwa district has a total of 23 public health facilities, including three HC IVs, 12 HC IIIs and 8 HC IIs. The district does not have a hospital, and relies on Mbale Regional Referral Hospital for its referrals above HC IV. The district's three HC IVs offer the lowest level of referral services, but the level of emergency preparedness for provision of maternal services, including services related to abortion and post-abortion care, was overall found to be low. The district does not have a functional ambulance. The existing two ambulances were very old and grounded by the time of this survey. Only two of the three HC IVs (Magale HC IV and Bugobero HC IV) have blood transfusion services; Manafwa HC IV does not.

The DHO reported that the health system of the district was in the process of being aligned with the national policy of prioritizing maternal and child health (MCH), which should be provided starting from HC IIIs. Hence, 8 HC IIIs were reported to have maternity and general wards and were thus capable of providing post-abortion care, save for cases of serious complications. The rest of the 3 HC IIIs were in the process of being revamped, according to information from the DHO's office.

However, these and other improvements in infrastructure will need to be accompanied by the needed human resources, operational funding and supplies to achieve improvements in service delivery. The staffing of key points of care has gaps. Manafwa HC IV does not have a medical officer and hence cannot provide theatre services. At the time of the survey, the district had only one medical officer, at Magale HC IV, which does not have an electricity connection and hence surgical services were limited. At the time of this survey, the medical officer at Bugobero HC IV was on leave. The other medical officer in the district is the district health officer (DHO), who is taken up by administrative work and is only available to provide care at Manafwa HC IV only occasionally.

Some basic equipment, such as equipment to test blood pressure and hemoglobin levels, is inadequate and yet it is key in the provision of maternal health services. The quality of care is compromised by reliance on clinical diagnosis due to limited availability of laboratory equipment. Vacuum aspiration equipment, used in cases of incomplete abortion, was reported to be particularly in short supply.

The office of the DHO also reported that medicine supplies were not only insufficient but also irregular. In addition, utilities are a major challenge and the primary health care PHC grants to facilities of Ushs4 million is insufficient to run a HC IV for the allocated three months, to cover utilities, maintenance, and fuel and staff allowances.


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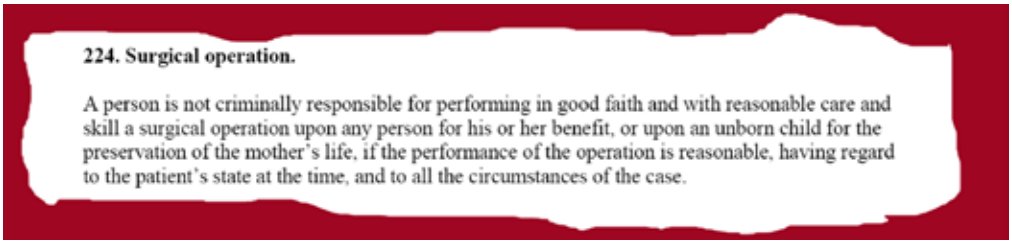
1.2 Legal framework on abortion

There is a persistent and widespread perception in Uganda that abortion is completely illegal and that therefore it is criminal to have one except only when done to save a woman's life (CRR et al., 2013). However, contrary to this perception, legal analysts have suggested that Uganda's abortion laws and policies are accommodative of abortion in a wider range of circumstances.

The Constitution, in Article 22(2), provides that "*No person has the right to terminate the life of an unborn child except as may be authorized by law*." The Constitution falls short of prescribing the circumstances for legal abortion, and the only existing law that attempts to prescribe the circumstances, the Penal Code Act, is not as elaborate on the circumstances as it is on the penalties.

The Penal Code Act allows termination of a pregnancy were the health and life of the mother are threatened by the continuation of the pregnancy and thereby gives a medical person or health provider allowance to safely terminate a pregnancy. It is important to note however that the same law criminalizes abortion.

Section 224 of the Penal Code provides that;



224. Surgical operation.

A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his or her benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time, and to all the circumstances of the case.

The above provision is widely understood to permit termination of pregnancy to safeguard the life and health of the pregnant woman. It presumes that termination of a pregnancy has been compelled by the need to preserve the life of the pregnant woman and therefore requires that the termination be conducted surgically with reasonable skill and care. Section 224 is in essence a legal defense meant to exempt liability for any person who could be liable for performing any of the criminal acts associated with termination of a pregnancy.

Whereas section 224 of the Penal Code Act permits termination of a pregnancy, Sections 141-143 criminalize the act of terminating a pregnancy and thereby prescribe a jail term of 14 years for anyone that attempts to induce an abortion in a woman "unlawfully"; a jail term of seven years for a woman who attempts on her own or allows a third party to induce an abortion in her; and a jail term of three years for anyone who supplies a drug or substance used in an "unlawful" termination of a pregnancy.

However, the law under section 224 of the Penal Code Act does not clarify what would amount to "good faith", the limits of the "patient's state"; and the "circumstances of the case" that it refers to. This has left the law, particularly this provision, vague and open to different interpretations. While some have limited the interpretation to saving the mother's life, others have interpreted "good faith" to mean having no financial motive and the circumstances to include the broader definition of health to include both physical and mental health (CRR 2012).

References have also been made to case law, particularly the 1938 case in which British gynecologist Aleck William Bourne was acquitted for performing an operation to terminate a pregnancy in a 14-year rape victim. At the time, British law only recognized justification for the termination of a pregnancy only if the life of the woman was in danger.

This ruling was reaffirmed in the 1959 East African Court of Appeal case of **Mehar Singh Bansel v. R, [1959] E. Afr. L. Rep 813.** *In this case, the Supreme court of Kenya defined an "illegal operation" as one "which is intended to terminate pregnancy for some reason other than what can, perhaps be best called a good medical reason," which the Court interpreted to be "the genuine belief that the operation is necessary for the purpose of saving the patient's life or preventing severe prejudice to her health."*

Given that British law was the basis for Uganda's original penal code, and considering the Cast African Court of Appeal had jurisdiction in Uganda, some analysts have argued that the incorporation of this ruling in Uganda's case law in 1959 effectively provided for circumstances for saving the woman's life and preserving her physical and mental health.

1.3 Policy framework on abortion

Ministry of Health has made steps towards clarifying these circumstances in the 2006 National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights (MoH, 2006). These provide that pregnancy termination is permissible in cases of fetal anomaly, rape and incest, or if the woman has HIV. The guidelines, however, do not have the force of law.

These and other different interpretations of the abortion laws have not only been inconsistent and confusing, but have also not helped clarify information about Uganda's abortion laws to women, healthcare providers, law enforcement, the judiciary and regulators, among others (CRR, 2012).

- The Ministry of Health's 2001 National Training Curriculum for Health Workers on Adolescent Health and Development provides that, "in the case of rape, [service providers can]… offer referral for abortion if appropriate and possible."
- The Ministry of Health's 2006 National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights and 2007 Management of Sexual and Gender Based Violence Survivors provide for access to termination of pregnancy in cases of sexual violence.
- There is no law, policy, regulation, or code of conduct in Uganda requiring that a health care provider consult with one or more other providers before performing a termination of pregnancy.
- Mid-level providers can offer termination of pregnancy and post-abortion care service – under the National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights
- There is no law, policy, or regulation in Uganda requiring that a woman obtain her husband's consent before receiving reproductive health services, including a termination of pregnancy.

1.4 Human rights and public health implications of abortion

In spite of the widespread perception that abortion is unlawful, Ugandan women from all socioeconomic and demographic backgrounds have abortions (Guttmacher Institute, 2013). The only national estimate of abortion incidence in Uganda, from a study conducted in 2003, put the annual abortion rate at 54 abortions per 1,000 women of reproductive age, or one abortion for every 19 such women (Guttmacher Institute, 2013). This rate is far higher than the average rate for eastern Africa, which estimates by the World Health Organization (WHO, 2011) put at 36 abortions per 1,000 women).

WHO has estimated that about one quarter of all pregnancies in the world end in induced abortion – approximately 50 million – each year. Of these abortions, 20 million are being performed under dangerous conditions, either by untrained providers or using unsafe procedures, or both (Berer, 2000).

It is largely women in higher social class who have access to a wider range of abortion providers and are more likely to use doctors, nurses and clinical officers, some of whom are able to provide relatively safe procedures (Guttmacher Institute, 2013). But this does not guarantee them a safe abortion.[1] Even skilled providers must work in clandestine environments, which often compromises the safety of the procedures they perform and frequently leads them to charge a high premium for their services (Guttmacher Institute, 2013).

No doubt, some of these abortions are not unlawful under the current abortion laws, given that Uganda does not prohibit abortion completely. However, because interpretations of the law are ambiguous, medical providers are reluctant to perform abortions for any reason for fear of legal consequences (Guttmacher Institute, 2013). Hence, access to safe abortion services, even for such legitimate cases, is extremely limited, leaving most women to risk their health and lives trying to end pregnancies with sticks, herbal concoctions, and other unsafe methods (Ipas, 2013).

At the national level, Guttmacher Institute (2013) observed that in 2008, Ministry of Health estimated that unsafe abortion-related mortality constituted 26% of maternal mortality and that for every woman who died from unsafe abortion, many more women suffered severe and permanent injuries.

1 According to the World Health Organization (WHO), unsafe abortion is “a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both” (WHO, 2003).

Besides being a public health challenge, unsafe abortion raises human rights concerns. Access to safe, legal abortion is a fundamental right of women, irrespective of where they live (Grimes 2006). The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa provides for abortion as a human right.

Article 14 (1) of the Maputo Protocol (Article 14[1]), provides that "States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted", including the right to control their fertility; the right to decide whether to have children, the number of children and the spacing of children; the right to choose any method of contraception. However, in ratifying this protocol in 2010, Uganda put a reservation on this article, which also obligates state parties to take appropriate measures "protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the fetus" (Article 14[2] [c]).

Nevertheless, it has been stated that governments violate the rights to health and life of women seeking abortion by making safe and legal abortion inaccessible and in ways that are specific to the enforcement of criminal abortion laws (Ipas, 2013).

At the national level, the 1995 Constitution of Uganda enshrines the inalienable and inherent human right of all individuals, including the responsibility of the State to fulfil the fundamental right of all Ugandans to social justice, basic medical services, healthcare, and economic development. In addition, the Constitution outlines the duty of the State to ensure that women are accorded full and equal dignity of person with men by protecting women and their rights, as well as their maternal functions in society (Article 33 [3]). As such, the State is obliged to provide reproductive health services and commodities that are necessary to enhance the welfare of women and girls, to enable them realize their full potential (Constitution Art 33 [2]).

1.5 Purpose of the action research project

In order to contribute to addressing the public health and human rights challenges arising from unsafe abortion, Center for Health, Human Rights and Development (CEHURD), working with partners like the African Rural Development Initiative (ARDI), has engaged community stakeholders in Manafwa district in eastern Uganda. The aim of the project was to foster understanding of Uganda's abortion laws among the selected stakeholders by sensitizing them on the circumstances under which the law permits abortion so as to create an enabling environment for women to access safe and legal abortion and post abortion care.

The target community-level stakeholders and actors have been engaged using a participatory reflection and action (PRA) process, dialogue, personal interviews, and documentation of cases of unsafe abortion and enforcement of abortion laws. This paper summarizes outcomes from these engagements and the emerging issues.

2. METHODOLOGY

This was an action research. It applied participatory approaches to analyze community-level understanding and application of abortion laws in Manafwa district.

2.1 Description of the project area

This action research engaged community stakeholders, representatives in Bumwoni sub-county, key duty bearers and informants at the district level in Manafwa District.

Manafwa is a rural district found in the eastern part of Uganda, along the Uganda/ Kenya border. It gained district status in 1999, after it was split from Mbale district. In 2006, the northern part of Manafwa district was carved off to form Bududa district. It has an estimated land area of 533 sq.km, lying on the slopes of Mt Elgon. It is bordered by Kenya in the east; Bududa district in the north; Mbale district to the West, and Tororo district in the South. The district headquarters at Manafwa are located approximately 27 km, by road, southeast of Mbale, the largest town in the sub-region.

According to UBOS (2012), the total human population of Manafwa district is 343,200, with 98% of the population rural based and only 2% living in the mushrooming trading centers of Manafwa and Lwakhakha Town Councils. The population predominantly comprises of Bamasaba who are the indigenous peoples of the area. The growth population rate is estimated 3.4% per annum.

The district lacks a hospital and is served by 23 health units. It has three health centre IVs – Magale HC IV, Bugobero HC IV and Bubulo HC IV. In addition, there are 12 HC IIIs and eight HC IIs.

The district faces a number of public health concerns and community challenges all which contribute to morbidity and mortality in the district such as malaria, pneumonia, intestinal worms, STIs, urinary tract infections (UTIs), anemia, eye infections and diarrhea.

2.2 Key informant interviews

The project team held one-on-one interviews with health program managers, law enforcers, service providers, civil society, community representatives and girls and women who have survived complications from unsafe abortion. The project team met and talked with the district police commander (DPC), the acting officer in charge of criminal investigations and the police officers in charge of the child and family protection unit; the district health officer (DHO); a senior clinical officer at Bubulo health center IV; the assistant in-charge, a midwife, and the records officer of Bugobero HC IV; a midwife and the in-charge of Bumwoni HC III; and six individuals who have witnessed unsafe abortion either as victims or as caretakers.

2.3 Participatory reflection and action session

A one-day participatory reflection and action (PRA) session was held with 35 representatives of the district health team, the police, civil society, victims of unsafe abortion, teachers, religious leaders, cultural leaders, political leaders and health providers.

The session convened on 3rd April 2014, at the premises of African Rural Development Initiatives (ARDI) in Lwakhakha sub-county.

1) To share information on safe, and legal abortion, Learn from the experiences and knowledge of participants, think critically together about the problem of unsafe abortion and its implications for public health and human rights;

2) To explore patterns in experiences and perceptions on unsafe abortion, to facilitate analysis of the problem of unsafe abortion at the grassroots level, including its nature, causes, and effects/impact

3) To brainstorm potential interventions that the community actors and stakeholders can take to address unsafe abortion and its public health and human rights effects;

4) To plan for community action against unsafe abortion: identify and share roles; identify available resources and opportunities within the community to implement effective community-led interventions to address the problem

The session was facilitated by CEHURD project staff, project consultant, district health officer, and district police commander.

A pre-test questionnaire was administered to the participants at the start of the session to guage their knowledge, attitudes and practices regarding abortion and PAC.


FIGHT

2.4 Community dialogue

A community dialogue was convened at Bumwoni Health Center III in Bumwoni sub-county in Manafwa District. The meeting was well attended by a wide cross section of community leaders including local council leaders, religious leaders, teachers, health workers, political leaders, police officers and community people among others. Facilitations were led by Gideon Wamasebu, the District Health Officer of Manafwa District and Miriam Khalayi a senior midwife at Bugobero Health Center IV.

The session was highly interactive with a cross section of issues being discussed including what abortion is and what types of abortions exist, the status of abortion in Uganda, the likely causal factors and consequences of unsafe abortions, what the law on abortion in Uganda is and the role of the community and various stakeholders in dealing with unsafe abortions.

At the end of the meeting, there was a very educative performance by the ARDI drama group which is a community-based organization drama group involved in rehabilitating victims of unsafe abortion in Manafwa district. The drama group performed plays and songs related to prevention of unintended pregnancies amongst teenagers, importance of family planning and the dangers of unsafe abortions which can lead to severe complications and loss of life.

The dialogue was concluded with clarity and agreement that there is still need for a lot of sensitisation on the nature and types of abortion, its implications on maternal health, and that the legal regime pertaining to abortion in Uganda needs to be demystified. The meeting was mostly conducted in Lumasaaba, the local area language, and in Luganda and English.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VISION
To realize social justice and human rights in the health systems in East Africa.

2.5 Sensitization of students

CEHURD convened a sensitization session for students at Lwakhakha Secondary School on 19 July 2014. The session was attended by about 70 students and teachers from Lwakhakha SS, Bumbo SS and Kisawayi Primary School. This meeting was facilitated by a police officer from Lwakhakha police station, a health worker from Bugobero HC IV, head teachers, the district health officer, and was crowned with a skit by drama group from Africa Rural Development Initiative (ARDI), a community-based organization involved in rehabilitating victims of unsafe abortion in Manafwa district.

At the end of the meeting, it was resolved that each of the participating schools will form a health club to continue with sensitization of fellow students in their respective schools and the respective committees to run the clubs were selected.

3. RESULTS AND EMERGING ISSUES

3.1 SCOPE AND NATURE OF UNSAFE ABORTION

3.1.1 Prevalence of unsafe abortion in Manafwa

In spite of the high level of stigma associated with abortion in Manafwa district, responses from the different categories of respondents indicated that unsafe abortion is a major problem in the district. All 35 participants in the PRA session for instance reported in a pretest questionnaire that abortion was a problem in their community, with one participant – a teacher – reporting in what sounded overstated, that "most women who abort end up dead". PRA participants reported that girls and women were dying prematurely, becoming barren and getting complications in an attempt to abort.

The district health officer (DHO), district police commander and officers in charge of investigations, child and family protection, school teachers, community, local leaders, health providers and religious leaders all reported that unsafe abortion is common in the district. Bugobero HC IV reported receiving an average of 25 patients in need of post-abortion care per month, while a total of 205 abortion cases were registered by public health facilities in the district over a period of 12 months.

> "*We are talking about cases of incomplete abortion; the complete ones do not come (to health facilities) including those that end in death. When they (cases of complete abortion) come, they are either septic or anemic; and someone could still tell you she had heavy periods, not an abortion*," – District health officer

The DHO informed us that from his observation, induced abortions are grossly under reported. At health facilities, most cases were reportedly registered as "incomplete abortion" or "miscarriage" (spontaneous abortion), even though it was obvious to health providers the majority of the cases are induced.

The high numbers of unsafe abortions were attributed to the high prevalence of unwanted pregnancies, which in turn were attributed to low use of contraceptives, cultural practices that encourages sex between strangers, high prevalence of child sex, incest, defilement, sex work and gender-based violence.


arriage
cancer caused by
pilloma virus (HPV)
EVENT pregnancy
planning method
ce
g/healtheducation
Services
Ressustation
Evacuation
Observation
DISCIPLINE

Respondents cited numerous examples of unsafe abortions that had ended in death in their community. In one case, a student died in an attempt to avoid the wrath of her "tough" uncle who was looking after her and paying her school fees. In another, a woman died in the process of aborting after she realized her absentee husband was returning soon. One PRA participant shared a case in which a neighbor's daughter infuriated her parents so much that they sent her away, only to be rejected by the partner's parents and her attempted abortion of the twins she was carrying ended her life in the process.

> "*A girl had sex with her uncle who forced her to abort and the girl got complications. We picked up and followed that case up to the end and now the case is in Mbale court but you see we as police officers also get challenges… we pick up cases but in most cases, witnesses decide to abandon the case and settle for money in exchange,*" – Police Officer, PRA session at Lwakhakha

3.1.2 Categories of women carrying out abortion

The main categories of women who abort in Manafwa district were cited as school girls, married women, victims of sexual assault, young girls whose partners deny responsibility for the pregnancy, and sex workers because of the nature of their work. Manafwa district borders Kenya and is host to Lwakhakha border post, which respondents said was a hotspot for female sex workers.

The project team was able to reach 11 women in Bumwoni sub-county who had carried out unsafe abortions or survived death arising from complications due to unsafe abortions or those that had a relative or daughter who went through an unsafe abortion. All the cases involved girls who were still pursuing their education at the time of the abortion. These largely justified their actions saying they were not ready to have a child, still wanted to pursue their education, and could not face the shame of delivering at their parents' home, feared tough parents, and a lack of support from partners or denial of responsibility by partners, among other reasons.

> "*My father had died and my mother was struggling to support me and my two siblings. The boy ran away and did not give me any help. I feared to be mistreated*," – Miriam, who aborted in senior two, at the age of 17

"I was in P.7 and the boy was in S.2 in another school. He looked like he had money because his father was rich and used to give me money because at times we used not to have food at home and also to buy some clothes. When I became pregnant he turned around. He told me he was still in school and was not ready to marry me and that his father was tough. He gave money and a friend of mine took me to a woman who removed it. It was painful and after sometime I had to go to hospital because the pain continued and I started to stink," – Violet, a survivor of death from an unsafe abortion in Bumwoni sub-county

3.1.3 Reasons for abortion

Women were reported to abort for different reasons. Students were reported to abort in order to continue with their studies, but also in a bid to avoid the wrath of their parents and guardians. Other adolescents abort because they consider that their partners do not have serious intentions of marrying them or that they are not the right men for them, and they think that having children makes them unappealingly older or are reluctant to create ties that may affect their opportunities for more fulfilling relationships in the future.

Married women were reported to abort for several reasons. Some abort pregnancies conceived in the absence of their husbands in order to save their marriage; some abort after disagreements with their husbands or as a precursor to separation; some abort to limit the number of children; some abort after their husbands have abandoned them and they feel unable to look after the (additional) child; and others abort after rape or incest to avoid continued psychological torture.

Some women abort due to ill health including fear of transmitting HIV to the baby; some abort on the orders of their husbands who help them procure abortion; while others abort because they think they consider their pregnancy to be socially unacceptable, for instance in cases where the mother considers herself too old to look after a baby or that the pregnancy causes them embarrassment.

> *"I have ever had a case of a woman who was brought to the facility with a stick in the vagina. This is common in this community; there are sticks that they believe induce abortion. I asked her why she decided to abort and her response was: 'Now look at us… we are old and all our children have grown-up and we even have grandchildren. How will our grand children look at us (giving birth to a baby at our age); it is embarrassing'"* – Midwife, PRA session at Rwakhakha

3.1.4 Abortion practices

Health workers, victims of unsafe abortion and community representatives reported that women commonly use a local herb locally known as *Lifafa*, to induce abortions. Other herbs were also identified as well as more crude methods, such as the use of cassava sticks, bed springs, metallic objects, medicine overdose and concoctions containing tea leaves, detergent and other substances.

Health providers reported that most of the induced unsafe abortions are done within 14 weeks of gestation. At which stage, the abortion is likely to be incomplete. At this stage the membranes are unlikely to clear out, the uterus will most likely bleed and the cervix traumatized.

Unlike induced abortion, spontaneous abortion rarely results in such complications or death, the district health officer reported.

3.2 STAKEHOLDER ATTITUDES AND PERCEPTIONS ON ABORTION

3.2.1 General perceptions

Overall, stakeholders who participated in the research had mixed reactions towards the subject of abortion and the circumstances under which it is allowed. It was clear that the perceptions where highly influenced by religion, customs and the poor understanding of the law.

Stakeholders participating in this work have been exposed to abortion or had encountered someone who had induced an abortion and noted that abortions do take place for various reasons. It is thus important to design educational programs on abortion for communities in Manafwa since the district has high numbers of uneducated people.

Those supporting selective abortion cited cases where the woman is a victim of rape and cannot find the man responsible for the pregnancy; when the partner denies responsibility; when a school girl has to continue with her education; when the man responsible or the victim has a mental disability; cases of incest; cases of fetal abnormality; and when parents have HIV, among others.

Those opposed to abortion cited the religious argument, the risks involved and that it is against the law. Even among health workers, program managers and women leaders in the district were stakeholders who felt that abortion should not be allowed under any circumstances, including rape and incest, except where the life of the mother is in clear danger. Health workers reported receiving women seeking abortion services and that they advised them against abortion and counseled them.

Among stakeholders who were not supportive of abortion, there was a feeling that the only "good" (acceptable) abortion is spontaneous abortion, and none of the respondents felt that poverty or inability to look after a child was reason enough to procure an abortion. For the opponents, "good abortion" was when there was a genuine and serious health problem that cannot enable the mother to successfully carry the pregnancy to term, while "bad abortion" is when it is done because of fear of responsibility.

There was a tendency for respondents to analyze the problem of unsafe abortion from the perspective of their responsibilities or mandate. For instance, teachers were concerned about school girls and the consequences of scampering their education; police about the challenges of identifying, pursuing and getting evidence to pin victims; and health workers about the risk of getting embroiled in legal processes when providing post-abortion care to women with incomplete abortion or post-abortion complications.


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3.2.2 Health workers

All health workers reached in this work said they did not offer abortion to women seeking the service because it is "illegal". None of them reported referring a client to a facility where the service could be provided. In at least one case, a health worker reported that a girl who was counseled and turned away, later returned in critical condition with unsafe abortion complications for post abortion care, suggesting that the counseling had not been helpful.

It was apparent that the health system regulations or at least the values of some health workers and program managers were not necessary inconsistent with social values. For instance, asked what a woman who is raped by HIV-positive stranger should do, a representative of the district health officer stated:

> "*Rape by a man with or without HIV is not a license for you to remove a pregnancy… There is PEP (post-exposure HIV prophylaxis) and PMTCT (prevention of mother-to-child transmission of HIV); it is available for rape victims. If you can bring the woman to a health facility within 72 hours, we will protect her and the baby from getting HIV*," – Facilitator from DHO's office at community dialogue in Bumwoni sub-county

3.2.3 Ordinary community members

At the community level, there were strong sentiments against abortion and it was apparent that abortion is highly stigmatized in Manafwa communities, with victims seen as sinners, murderers, promiscuous and other forms of social misfits who should be arrested and prosecuted. Women who had ever aborted narrated details of how they tried to keep the act secret for fear of the law and more because they would be ridiculed by relatives and the community. Some respondents believed that a woman who aborts will be ashamed and may feel guilty and unhappy, and that "their name will be spoilt".

> "*It (abortion) has caused a number of deaths, barrenness to some girls and sometimes rejection in the home, etc*" – 28-year old married female

> "*There is no good abortion; it is against God's intention*," – 70-year old retired church minister

> "*There is no good abortion; all abortions can kill*," – 52-year old female village health team member

One victim of unsafe abortion narrated her ordeal which became public knowledge that she had aborted after she became critically ill and had to be treated for severe post-abortion complications.

> "*After I spent a week in hospital, they brought me back home. Villagers had gathered pretending to sympathize with me but they were just mocking me. My mother told me that I had ashamed her and that the entire village was talking about me. As a punishment she said she would not take me back to school until the following year*," – Agnes, who aborted at the age of 16 in senior three

3.2.4 Youth

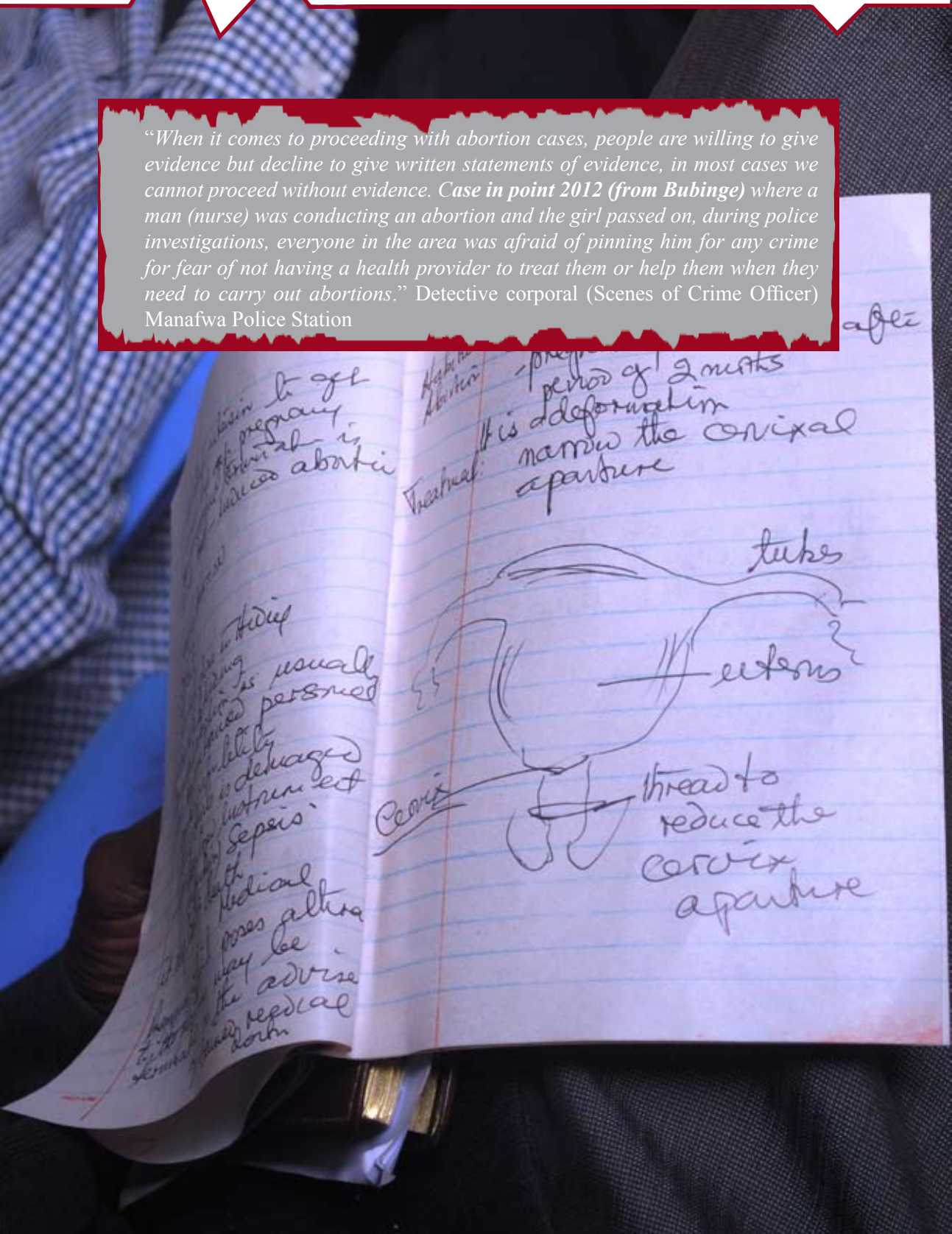
Young people did not seem curious about abortion and its complications during the sensitization session. Reacting to presentations about abortion, post-abortion care and how to prevent unwanted pregnancies, students were more interested in broader issues of reproductive health, particularly HIV/AIDS. On the issue of abortion, there were more questions about prevention of unwanted pregnancy than on any other topic. Students asked about the safety of contraceptives for people of their age; why some girls who use condoms still get pregnant; how "safe days" can prevent pregnancy; whether a woman on contraceptives can still menstruate; and whether a woman who uses contraceptives can still conceive by "artificial fertilization", among other questions.

3.2.5 Police

When asked about measures to minimize unsafe abortion in the community, one respondent amongst law enforcers suggested that the communities and health workers need to be "sensitized" so as to help police prosecute and take "the criminals", including the woman and "all the accomplices", to prison. Law enforcers frequently used the phrase "criminal abortion" to mean induced abortion and on a few occasions, there was reference to "loss of life for an innocent baby" as one of the consequences of abortion. Below are some of their perceptions on abortion;-

> *"Medically induced abortion is legal but abortions are illegal where they have been induced by an individual. We have no problems with medical abortions, however people who do it in their homes without a doctor authorising it is illegal," Assistant Superintendant of Police, Manafwa District.*

> *"Most cases are not reported to police but abortions take place and the only time they are reported is when it is too late. And as police, we handle abortion cases mainly handled as a crime but maternal health is wide,"* Acting O/C CID



"*When it comes to proceeding with abortion cases, people are willing to give evidence but decline to give written statements of evidence, in most cases we cannot proceed without evidence. **Case in point 2012 (from Bubinge)** where a man (nurse) was conducting an abortion and the girl passed on, during police investigations, everyone in the area was afraid of pinning him for any crime for fear of not having a health provider to treat them or help them when they need to carry out abortions*." Detective corporal (Scenes of Crime Officer) Manafwa Police Station

3.3 PROVISION AND UPTAKE OF FAMILY PLANNING, ABORTION AND POST-ABORTION CARE SERVICES

3.3.1 Provision and uptake of family planning services

Family planning services are available at most health facilities, including all HC IIIs and HC IVs, and largely supported by Marie Stopes, a non-state service provider. However, capacity to provide long-term and permanent methods was very limited due to lack of supplies and the requite skills among midwives. To cover the gap, Marie Stopes makes outreach visits to four different health units in the district to administer the long-term and permanent surgical methods on a monthly basis, but respondents reported that uptake was still below expected levels. Health providers reported that there was higher preference for the three month injection in comparison to other short-term, long-term and permanent methods. For instance, in the month of March, outreach visits to four facilities registered only 23 women choosing the long term and permanent methods, in comparison to more than 200 women that received injections.

The preference for the injections was attributed to the fact that women consider it to be convenient because it can be safely used without the knowledge or consent of the male partner. In the March 2014 outreach visits, only four men attended the family planning camps, reflecting a general lack of male involvement in maternal health interventions.

Uptake and utilization of family planning was overall reported to be poor in Manafwa district due to fear of real and presumed side-effects, a limited choice of options, lack of knowledge, opposition from some men, and limited supplies, among other barriers. PRA participants reported the most common method of contraception used to be the three-month injection (Depo Provera), but estimated the proportion of sexually active women who use contraceptives to be fewer than one in 10.

"Around the year there is family planning but very few women come for contraceptives. We have pills, injectables and Marie Stopes brings IUDs, implants and permanent methods but only depo (injectables) moves. Marie Stopes mobilizes during the camp… they make announcements over the radio in the local language but the turn up is sometimes not good," – Respondent at Bubulo HC IV

Condoms are availed in the waiting area of some health centers. They are also distributed to clients of antenatal care (ANC), but respondents at Bubulo HC IV said the mothers throw them along the way back home for fear of being confronted by their husbands. Women are encouraged to come with their partners but the response from men was reported to be generally poor and all attempts to encourage men to accompany their spouses for ANC has reportedly resulted in men paying boda-boda (commercial) motorcyclists who deliver the women to the health units to pose as their husbands.

"We are promoting couple counseling but you will get to realize that the boda-boda man keeps appearing with different women pretending to be their husband and definitely you will question yourself whether he is not fooling you… we realized men pay boda-boda men to represent them. We are making progress because we now get about 30 couples a month but men are very hard to deal with, you may not tell whether the man accompanying the woman is the husband or not," – Respondent at Bubulo HC IV.

3.3.2 Provision and uptake of abortion services

Health providers believe that inducing an abortion is illegal, except when it is done to save the life of the mother, and for this reason, public health facilities do not provide abortion services on request. Even then, they reported that they have on a few occasions received clients seeking assistance to abort and they have had to turn them away. Cases of health providers recommending or providing abortion to women in the interest of their health were reported to be rare.

It was reported that some health workers in public as well as private health facilities have clandestinely provided abortion at a fairly hefty cost of Ushs300, 000. PRA participants reported about a clinic in neighboring Lwakhakha border town that charges Ushs50, 000 for abortion services. In Mbale town in neighboring Mbale district, one clinic was reported to be well known for providing abortion services under the guise of providing care to victims of "incomplete abortion".

Most abortions take place in the community, outside of the health system. Some herbalists provide the service at a modest Ushs10, 000. A two-time victim of an unsafe abortion narrated details of her ordeal where on one of the occasions, a traditional practitioner pushed a cassava stem through her vagina to pierce the uterus in a painful process that failed on the first attempt, setting off a bloody ordeal that was only tamed several days later at Bumwoni HC III.

In some cases, the victims induce the abortion on their own. Some take all kinds of concoctions, such as a mixture of stale urine and detergent, an overdose of Chloroquine or other tablets, and a range of self-administered local herbs, including one that involves placing and keeping a slow-acting piece of stick in the vagina for several days. This finding was corroborated by health providers who reported finding sticks in women reporting to facilities with post-abortion complications.

3.3.3 Provision and uptake of post abortion-related care

Health providers reported that victims of unsafe abortion rarely tell the truth when they report to health facilities with post-abortion complications; they come complaining about fever/malaria, headache and other irrelevant excuses. Matters are usually complicated when they are accompanied by a parent concerned about why their daughter can no longer attend school.

> *"When laboratory tests turn out negative, the foul smell is usually what gives them away. It is beyond ordinary sense and it is up to the service provider to be creative in the presence of harsh parents when the patient's interest should be paramount. When I was in practice, I was confronted with such a case but I had to complete the abortion, give anti-malarial and ask the girl to return in the afternoon so as to handle the sepsis," – district health officer*

He reported that in one case, the victim, a school girl who wanted to avoid the wrath of parents and continue with school, thought that the birth canal was straight and tried to use a bed spring to puncture the uterus but ended up piercing the pouch of Douglas, which is at the back of the uterus, leaving the fetus intact. The girl continued to deny attempting to abort until the bed spring was pulled out to her embarrassment. The DHO, then still in full active service, informed the research team that he repaired the damage and counseled the girl to carry the pregnancy and she later had a healthy baby.

However, the DHO and health workers reached in work reported that post-abortion care services are provided at all health facilities in the district, free of charge.

3.4 COMMUNITY PERCEPTIONS OF ABORTION LAWS, HUMAN RIGHTS AND PUBLIC HEALTH

3.4.1 Overall understanding of the abortion law

This action research found widespread perceptions among law enforcers, religious leaders and ordinary community members that abortion is not only morally wrong, but also equivalent to murder, and that legal sanctions against culprits were justified.

In a PRA pre-test questionnaire, only a couple of participants, who happened to be health workers, felt that abortion should be allowed in selected circumstances, including in trying to save the mother's life as well as in cases of incest and sexual assault, particularly rape.

The majority of session participants responding to the pre-test questionnaire largely felt that abortion was unacceptable. At least two participants, including a woman LC V councilor, stated that there was nothing like "good abortion". Some participants felt that abortion should not be allowed whatever the circumstance because "it is bad" and a "sin", and that health providers should save life, not end it. In at least one response, it was suggested that the only abortion that should be allowed is the spontaneous abortion.

> *"A woman who aborts should be punished because it is against the law and she can die. The community should report to the nearest police,"* –LC V Woman Councilor

> *"It is a criminal case whereby we need to sensitize the communities so that they avoid dangerous death,"* – Police Officer

The police officer suggested that any woman who aborts or attempts to abort risks their life and should be arrested. She added that health workers should assist in the arrest of such people, and the community should report them to police so they can be "taken to court for punishment". The respondent also recommended arrest for anyone who provides drugs to a woman to induce an abortion.

According to the officer, the legalization of abortion should not and cannot be considered, and that the only way to minimize unsafe abortion in the community is to enforce the existing law and to report culprits to the nearest police station for arrest and prosecution. Asked whether the legalization of abortion would reduce cases of unsafe abortion, one of the participants of the PRA session stated that it was bound to worsen the situation and "you cannot legalize the killing of something that was created; that is murder".

Responding to a question of how many people thought abortion is illegal, more than 20 hands (out of about 35 participants) were up, but none could cite the law that outlaws abortion.

> *"For us we know that it is illegal because we see police arresting people who abort," – PRA participant*

It was noted during the PRA session that fear of police, particularly its approach of carrying out arrests of suspected culprits and accomplices, including health workers offering post-abortion care, was not only scaring away girls and women from the formal health system and health workers from providing services for post-abortion complications but also making girls and women more scared of pregnancy than of HIV.

3.4.2 Understanding of the link between unsafe abortion, human rights and public health

Participants during the PRA session had limited knowledge of the link between unsafe abortion, human rights and public health. They tended to consider the problem of unsafe abortions, more as a social rather than as a public health and human rights issue. For instance, only a couple of participants could successfully cite three human rights that could be violated when a woman has an unsafe abortion. Indeed, most participants at the PRA session, including local leaders, law enforcers, teachers and other key stakeholders, could not cite even a single human right that is violated when a woman has an unsafe abortion.

It was apparent that stakeholders at the community level had little sympathy for victims of unsafe abortion and had little consideration for gender dimensions of the problem. At the extreme, one police officer appeared to understand the human rights that may be violated when a woman has an unsafe abortion in terms of the rights that the victim could either violate or forfeit – citing "the right to life"; "right of freedom"; and "right to associate with others in the community".

And on the consequences of unsafe abortion, one female teacher stated that "The husband may not have children from that woman again"; and that "the community will look at that woman as a killer"; and that, for government, "the number of future voters will be reduced" as future voters are aborted before birth. Another teacher considered abortion an act of "child abuse".

The findings indicate that the criminalization of abortion and practices relating to its enforcement and public understanding and perceptions of the provisions of the law is having a major effect on provision and utilization of abortion and post-abortion care in Manafwa district.

nHealth providers participating in this survey reported that they had experienced or witnessed cases of police harassment of health professionals to provide evidence in cases of abortion. On the other hand, police officers reported difficulties in requesting health workers to support investigations and prosecutions of culprits engaged in conducting unlawful abortions even where the women has passed on as a result of the abortion.

For fear of being prosecuted, boys were reportedly encouraging their girlfriends to abort and in most cases they have been in position to access unsafe, self-administered abortion induced by use of herbs or procured from traditional practitioners.

"There was a recent case where a boy impregnated a girl and the boy was arrested and released on police bond. But then I think the boy wanted to kill the evidence so he connived with the girl to abort. The girl came here bleeding with incomplete abortion. The father of the girl went back to police and after the police arrested the boy and the girl, they (police) came here looking for evidence, asking for the file of the girl to see what we diagnosed.

That kind of thing is scaring many health workers from providing post-abortion care because if ever the girl was to die in your hands, they will take you as an abortion accomplice and people want to avoid such inconvenience," – Respondent at Bubulo HC IV.

4. SUMMARY OF RECOMMENDATIONS AND CONCLUSION

4.1 Summary of recommendations

- Current guidelines in Uganda related to abortion focus mainly on post-abortion care (PAC) but do not systematically address the need for standards and guidelines for prevention and management of unsafe abortion, or the legal framework for abortion care and aftercare.

  To fill this gap, and to provide a basis for regulating and standardizing quality of care, as well as for coordinating and guiding the provision of service interventions and approaches across health facilities and different sectors, this document, *Standards & Guidelines for Reducing Morbidity & Mortality from Unsafe Abortion in Uganda*, has been developed. The Guidelines assist stakeholders in decision-making by describing a range of generally acceptable approaches to achieving the standards set forth in this document.

  Stakeholders should attempt to apply guidelines in good faith, to meet the needs of clients and improve the health of the community and country at large. The Standards detail the minimum requirements that should be met by all facilities, health care workers, and other stakeholders providing sexual and reproductive health education and services. Standards can be used to ascertain the level of deviation from acceptable practice in the provision of medical care.

- There is need to create synergies amongst different stakeholders including police, civil society organizations in Manafwa, teachers, health providers and the community leaders in educating the community and students on preventing unintended pregnancies, the dangers of unsafe abortions and importance of post abortion care where an unsafe abortion has been carried out.

- Sensitize communities on the provisions of the law on abortion; opportunities for safe and legal abortion; availability of post-abortion services; dangers of unsafe abortion; and their role in advocating for legal reform.

- Promote uptake and utilization of family planning through expanding supplies, training health workers in the provision of long-term methods to increase options; encouraging male involvement; and providing incentives.
- Improve the capacity of health facilities to provide safe, legal abortion and post abortion counseling and care.
- Enhance knowledge of the law by health providers and enforcers, including local leaders and police officers in relation to the abortion laws and policies.
- Sex education should target school-age adolescents to enable boys and girls to make informed decisions in sexual relations.
- Speed-up the formulation of service guidelines and standards to provide guidance to health providers in providing care to victims of unsafe abortion.
- Advocate for reform of the abortion law to align it with practical realities on abortion, including clarifying circumstances for legal abortion.

4.2 Conclusion

Practices resulting from fear of the real and perceived illegality of abortion are undermining access to safe, legal abortion and post abortion care in Manafwa and most likely elsewhere in Uganda. The fear of the law and its enforcement mechanisms has not barred girls and women from abortion, but driven it underground.

Law enforcement, including enforcement of the abortion laws, has taken a punitive approach with little attention to prevention and community buy-in. While the community is largely aware of the continuous abortion practice in the community, duty bearers remain silent even where there is loss of life. It is thus pertinent that programs to reduce death from unsafe abortion are designed to concurrently target communities, law enforcers and health workers.

More community engagement on the subject creates a platform for discussion and enables community to develop or initiate solutions or mechanisms to deal with the problem.

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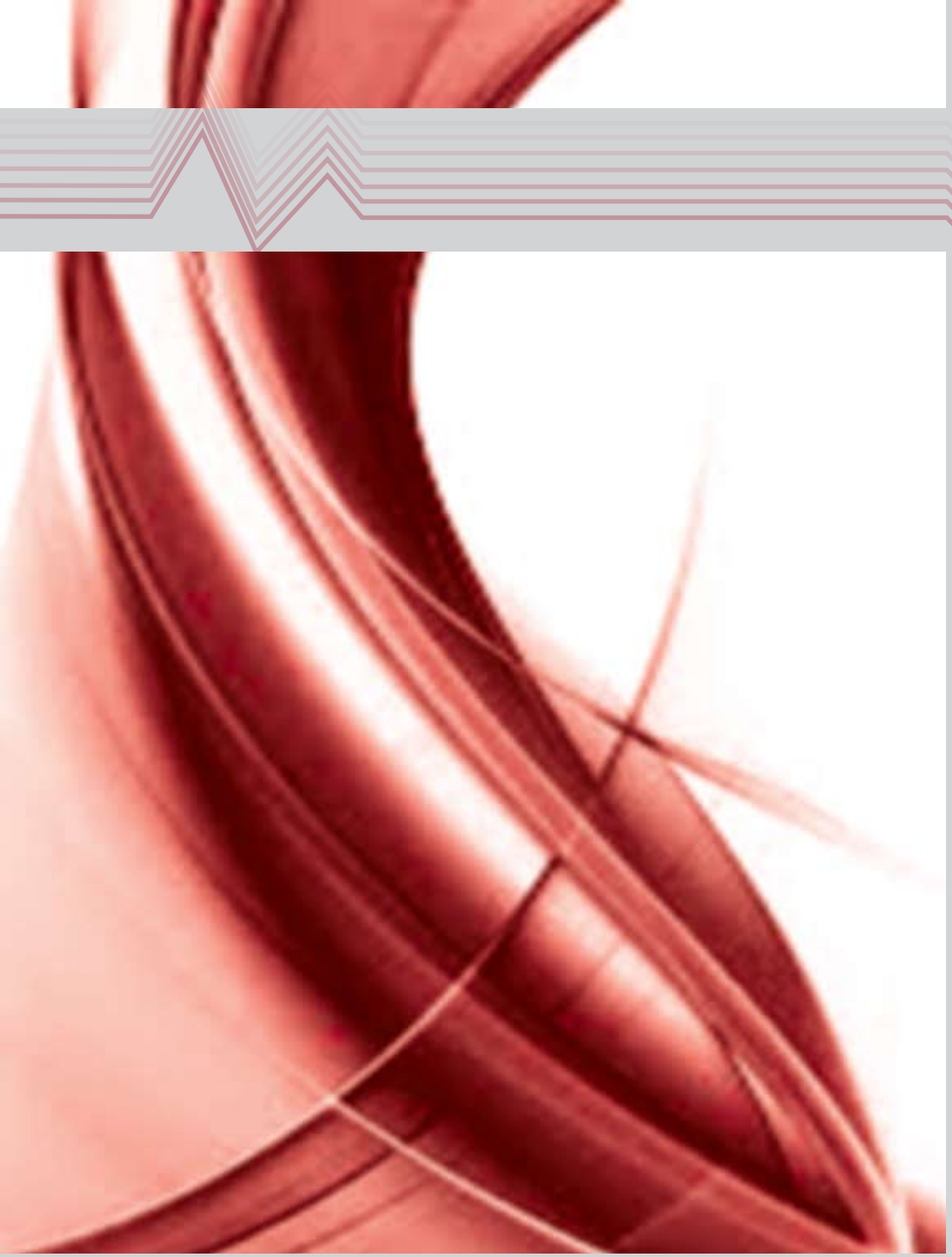

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