

FACING UGANDA'S LAW ON ABORTION

*Experiences from Women &
Service Providers*

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CEHURD
social justice in health

**CENTER
FOR
REPRODUCTIVE
RIGHTS**



Foreword

Uganda's law on abortion prohibits several acts and omissions relating to abortion and sets out to punish women and health workers who perform any of the prohibited acts. And yet it should also be noted that every woman has a right to make decisions relating to her reproductive health and this decision includes the right to terminate or keep a pregnancy. This right can be read into the obligation of the state to provide medical services to the population, to enable women in exercising their full reproductive and maternal functions and the exception to the right to life that prescribes the development of a law that provides for instances in which a pregnancy may be terminated.

Abortion affects girls, women, health workers, lawyers, police, and communities, with victims being particularly stigmatized. The stories and perspectives in this booklet demonstrate the need for access to safe abortion services in Uganda.

It is unfortunate that no effort has been made to take advantage of the opportunity that is presented by Article 22 (2) of the Constitution to create a law that provides specific instances in which an abortion is permitted. Despite the significant progress in the policies that relate to access to safe abortion services, the law has barely moved an inch since the Constitution of Uganda came into force.

It cannot be by coincidence that the prosecution of offences relating to the termination of pregnancy has resulted in injustice in Uganda. In some instances health workers have been arrested for providing post abortion care, in other instances girls have been manipulated into accepting conviction without legal representation and in other instances prosecutors have failed to find evidence that implicates the accused and the cases have been dismissed. Unfortunately by the time the cases are dismissed, the reputation and confidence of the health workers and women involved have been tarnished beyond repair.

The criminalisation of abortion has had the effect of restraining health workers from providing safe abortion services for fear of prosecution which in turn has led to the inability of women to access the services. Women and girls who need to access safe abortions are therefore left with no option but clandestine and unsafe services which often have fatal consequences contributing to Uganda's high level of maternal deaths.

We need all of the help that we can get to reduce the prevalence of maternal mortality in Uganda. With unsafe abortions contributing to over a quarter of all maternal mortality in Uganda, there is need to address the underlying factors that lead women into seeking unsafe abortions. Health workers need to operate in an environment without fear of being arrested and harassed. In turn, women should be able to seek safe abortion services knowing that they will not suffer stigma or be punished for services they need.

Clarifying Uganda's abortion law should be accompanied by the expansion of instances for which abortion can be accessed –such as cases of incest, rape, defilement and other indications in which the health and life of the woman may be threatened. Beyond the law, there is need to improve socio-economic conditions and increase access to contraception and family planning services to minimize abortion and unwanted pregnancies.

I hope that this booklet will shed some light on the plight of pregnant women in Uganda, the factors that contribute to the unacceptably high number of unsafe abortions and maternal mortality in Uganda. I believe it will surely complement the efforts to realise a safe legal environment for women to access safe and lawful abortion services.

Moses Mulumba
Executive Director

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Abbreviations and acronyms

CAC	Comprehensive Abortion Care Services
CEHURD	Center for Health, Human Rights & Development
CRR	Center for Reproductive Rights
DPP	Director of Public Prosecutions
HC	Health Center
ICESCR	International Covenant on Economic Social and Cultural Rights
IEC	Information Education And Communication
LC	Local Council Chairman
MOH	Ministry of Health
SRHR	Sexual And Reproductive Health And Rights
UPMA	Uganda Private Midwives Association
Ushs/UGX	Uganda Shillings (Currency)
WHO	World Health Organization

Introduction

Maternal mortality continues to be a formidable factor in the realization of sexual and reproductive health and rights (SRHR) in Uganda. Indeed 343 women out of every 100,000 women die from preventable pregnancy-related complications each year and many more suffer serious and often permanent disabilities¹. Unsafe abortions contribute to 26% of maternal deaths, as a result of the legislation that criminalizes abortion.² This 1950 law (the Penal Code Act) has had harmful effects on a diverse range of stakeholders particularly women and girls as well as health care providers who have been often threatened with arrests or have actually been arrested. Some have been tried and sentenced to prison, some have served their sentences to the end, while others have spent days in detention and, in some instances, been released with no charge filed against them.

Given that background, the Center for Health, Human Rights & Development (CEHURD), in collaboration with the Center for Reproductive Rights, has collected a number of these stakeholders' voices and perspectives into a photo voice booklet. The purpose of this booklet is to evoke for the reader the reality of the situation in Uganda. It specifically speaks about the impact of the criminalization of abortion in Uganda. It offers an array of voices: a girl who was defiled and denied access to abortion services, a woman imprisoned for procuring an abortion, a health service provider detained for providing post-abortion care, a law enforcement officer, a gynaecology/obstetrician/midwife involved in providing abortion and post-abortion care, a legal practitioner who specializes in abortion law, and the voices of girls that have procured unsafe abortions—among others.

We hope that these voices have the power to create space for the rights holders and duty bearers to speak out on these key issues and bring about change. We believe that sharing these stories will strengthen the case for legislative reform and lead to a decrease in the high rates of maternal mortality and morbidity in the country as well as realization of the rights of women.

Methodology

This booklet has been compiled using a combination of key informant interviews with relevant stakeholders and desk research. Informants were purposely selected to fulfill various perspectives as enumerated above.

Interviews were conducted across Uganda wherever an interviewee who fulfilled any of the criteria was identified. The languages in which the interviews were conducted include English, and Lusoga, Luganda, and Lumasaba –languages that are widely spoken in Uganda. All interviews were translated into English.

The desk research reflected in this booklet was conducted to analyse the regulatory and policy framework on abortion in Uganda to contextualise the stories documented.

State of the law on abortion in Uganda today

THE CONSTITUTION OF THE REPUBLIC OF UGANDA

Article 22. protection of right to life

1. No person shall be deprived of life intentionally except in execution of a sentence passed in a fair trial by a court of competent jurisdiction in respect of a criminal offence under the laws of Uganda and the conviction and sentence have been confirmed by the highest appellate court.
2. No person has the right to terminate the life of an unborn child except as may be authorised by law.

To understand the scope of the law on abortion in Uganda, it is important to appreciate the whole scope of the legal and policy framework under which it is provided. Abortion law in Uganda has been spread across a number of legal and policy instruments, which all have to be traversed to get a comprehensive understanding of the position of the law.

The Constitution of the Republic of Uganda is the supreme law from which all others laws in Uganda naturally flow. Article 2 (2) of the Constitution as such nullifies any law or custom that is not consistent with its provisions.

State of the law on abortion in Uganda today

Uganda's legal framework on abortion is spread across the Constitution of 1995, the Penal Code Act of 1950 and case law that has a bearing on the interpretation of the provisions of the law.

3.1 The Constitutional Foundation

In Uganda, the Constitution is the main law and provides for abortion as an exception to the right to life by recognizing two key aspects which are important to the regulation of abortion. The first part of Article 22(2) of the Constitution recognizes the life of an unborn child by expressly providing that no one has the right to terminate it.

The second part of Article 22(2) of the Constitution anticipates that there may be situations in which a person may terminate the life of an unborn child and provides that such situations have to be authorized by law. In putting these two parts together, Article 22(2) may be interpreted that while no person has the right to terminate the life of an unborn child, the law may authorize a person to terminate such a life.

2. Protection of right to life

(1) No person shall be deprived of life intentionally except in execution of a sentence passed in a fair trial by a court of competent jurisdiction in respect of a criminal offence under the laws of Uganda and the conviction and sentence have been confirmed by the highest appellate court.

(2) No person has the right to terminate the life of an unborn child except as may be authorized by law.

In Uganda, only one body has the authority to make a provision having the force of law as has been defined by Article 22(2) of the Constitution. Article 79 of the Constitution provides that the Parliament has powers to make laws on any matter such that no person or body other than Parliament can make provisions having the force of law in Uganda except under authority conferred by an Act of Parliament.

79. Functions of Parliament

(1) Subject to the provisions of this Constitution, Parliament shall have power to make laws on any matter for the peace, order, development and good governance of Uganda.

(2) Except as provided in this Constitution, no person or body other than Parliament shall have power to make provisions having the force of law in Uganda except under authority conferred by an Act of Parliament.

(3) Parliament shall protect this Constitution and promote the democratic governance of Uganda.

The Penal Code Act, Cap 120, Laws of Uganda

The only provisions with the force of law which relate to termination of pregnancy in Uganda are found in the Penal Code Act. Section 141, 142, 143 and 212 of the Penal Code Act provide for offences relating to the termination of the life of the unborn child before it proceeds out of the body of the mother. Section 141 prescribes imprisonment of 14 years for a person who is convicted for performing any action intended to terminate the pregnancy of a woman.

Section 142 prescribes imprisonment of 7 years for any woman who is convicted for performing any action intended to terminate her own pregnancy. Section 143 prescribes imprisonment of 3 years for any person who is convicted of supplying anything intended to be used to terminate a pregnancy of a woman. Section 212 on the other hand prescribes life imprisonment for a person convicted of performing any action which terminates the life of the unborn child and thus prevents the child who is about to be delivered from being delivered alive.

141. Attempts to procure abortion

Any person who, with intent to procure the miscarriage of a woman whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means, commits a felony and is liable to imprisonment for fourteen years.

142. Procuring miscarriage

Any woman who, being with child, with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means, or permits any such things or means to be administered to or used on her, commits a felony and is liable to imprisonment for seven years.

143. Supplying drugs, etc. to procure abortion

Any person who unlawfully supplies to or procures for any person anything, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman, whether she is or is not with child, commits a felony and is liable to imprisonment for three years.

212. Killing unborn child

Any person who, when a woman is about to be delivered of a child, prevents the child from being born alive by any act or omission of such a nature that if the child had been born alive and had then died, he or she would be deemed to have unlawfully killed the child, commits a felony and is liable to imprisonment for life.

Section 224 of the Penal Code Act has been interpreted as having the authorizing provision on termination of abortion in Uganda. The Section excludes criminal liability for a person who in good faith and with reasonable skill and care performs a surgical operation on any person for that person's benefit or upon an unborn child to save the mother's life, if the operation is reasonable having regard to the patient's state at the time and to all circumstances of the case.

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.

A literal reading of Section 224 provides that the criminal liability is only excluded for a health worker who uses a surgical operation to terminate a pregnancy but cannot be interpreted to entitle a woman to demand the termination of her pregnancy. The health worker is entitled to exercise his or her discretion in the circumstances of the case and in light of the state of the patient to determine whether indeed he or she should perform a surgical operation on the unborn child to save the mother's life.

Only the Penal Code Act has provisions with the force of law relating to abortion. However, the Ministry of Health has taken cognizance of the limitation of the law and has advanced its policy provisions for access to safe abortion services. The 2006 — and its replacement — the 2012 National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights provide guidance for the management and prevention of unsafe abortion and highlight several medical indications on which a person can access comprehensive abortion care.³

The indications highlighted include severe maternal illnesses threatening the health of a pregnant woman e.g. severe cardiac disease, renal disease, severe pre-eclampsia and eclampsia, severe foetal abnormalities which are not compatible with extra-uterine life e.g. molar pregnancy, anencephaly, cervical cancer and HIV-positive women requesting for termination. These indications – it can be argued – fall within the “threat to life” exemption provided by Section 224 of the Penal Code Act.

The Policy Environment

NATIONAL POLICY GUIDELINES FOR SEXUAL AND REPRODUCTIVE HEALTH SERVICES 2012

Comprehensive Abortion Care Services (CAC)

This is health care provided to a woman or a couple seeking advice and services either for terminating a pregnancy or managing complications arising from an abortion.

People who can get services for termination of pregnancy:

Severe maternal illnesses threatening the health of a pregnant woman e.g. severe cardiac disease, renal disease, severe pre-eclampsia and eclampsia;

Severe foetal abnormalities which are not compatible with extra-uterine life e.g. molar pregnancy, anencephaly;

Cancer cervix

HIV-positive women requesting for termination; In accordance with bullet one above

Rape, incest and defilement.

The provisions in the policy documents relating to access to comprehensive abortion services in Uganda do not prescribe law but provide useful guidance for the interpretation of the laws that provide for abortion. They set a standard in medical practice that should guide the provision of access to safe abortion services in Uganda.

The National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights (2012) provide direction and focus in provision of reproductive health services and clarify the roles of the different actors involved in planning, implementation, service provision, monitoring and evaluation.⁷ These Policy Guidelines and Service Standards also spell out the general rules and regulations governing reproductive health services, components of reproductive health services, target and priority groups for services and basic information education and communication (IEC) for the target and priority groups.⁸

Ministry of Health has followed up these Policy Guidelines and Service Standards by developing the Standards and Guidelines on Reducing Maternal Morbidity and Mortality from Abortion in Uganda⁴ to guide health providers on the provision of comprehensive abortion care. The Standards and Guidelines are currently under consideration by the Ministry of Health.

From the above discussion it is deducible that the law on abortion in Uganda is quite complex and confusing. While the policies providing for comprehensive abortion care have been rather progressive, their lack of binding force on the courts of law still presents a barrier to clarifying the law on abortion in Uganda. It is therefore imperative that a holistic approach be taken when appreciating the law on abortion so as to bring all the relevant pieces of law and policy together.

Accessing lawful and safe abortion services

When a woman or girl qualifies for a lawful abortion, it is essential that she be able to access one when she needs it. But due to a number of barriers like a restrictive legal environment, lack of information on how to access safe abortion services and stigma against those who seek abortion services, accessing safe and lawful abortion services is quite difficult.

The Ministry of Health through the 2006 National Policy Guidelines and Service Standards recommended that in some instances the woman or girl should be assisted to terminate the pregnancy. These instances include severe maternal illnesses threatening the health of a pregnant woman e.g. severe cardiac disease, renal disease, severe pre-eclampsia and eclampsia; severe foetal abnormalities which are not compatible with extra-uterine life e.g. molar pregnancy, anencephaly; cancer cervix; HIV-positive women requesting for termination; rape, incest and defilement⁹. The 2012 National Policy Guidelines and Service Standards which replaced the 2006 version retained these provisions and the Standards and Guidelines for the reduction of Maternal Mortality and Morbidity from Abortion which are still being developed similarly retain the same permissions for termination of pregnancy.

Accordingly, a pregnant girl or woman who presents herself to a health service provider with an unwanted and risky pregnancy as a consequence of any of the mentioned medical indications or is a victim of rape, incest or defilement has the right to be provided with the required form of abortion care.

In March 2014, Nabukeera Sarah (pseudonym) was drugged and defiled by a health worker when she went to a health facility for treatment. Because of the stigma surrounding abortion, she could not walk to a health facility and request for a termination of her unwanted pregnancy and yet being a victim of sexual

violence, she was clearly entitled to the services. She was forced to obtain a clandestine abortion.

For many girls, the decision whether to abort or not is influenced by whether they can continue with their education or not. In addition to the stigma that comes with being pregnant while in primary school, it is common for parents in rural areas who are struggling to get by to marry off their pregnant daughters to avoid the burden of taking care of another child. This effectively means that the girl will never have an opportunity to go to school again having since become a wife.

The 2012 National Guidelines and Policy Service standards prescribe that victims of incest, rape and defilement can access comprehensive abortion care and prescribe that termination of pregnancy through medical induction and surgical induction can be conducted at a health facility from the Health Center IV level all through to the referral hospital level.¹⁰

Unfortunately, this information has not been made available to both the health workers who provide the services and to girls who need it like Nabukeera Sarah. Regardless of the policy space that has been opened, access to information regarding the availability of the services becomes a barrier to access to the comprehensive abortion services because the health workers do not know whether they are permitted to provide comprehensive abortion services. In turn, this leaves girls and women unsure as to whether they can access the services and if so, from where they can access them.



Nabukeera Sarah, 15 Years

Around March 2014, I felt stomach pains and sought my mother's permission to go to hospital. I went to Walukuba Health Center IV. While there, I met Dr. Alex who treated me and gave me medicine that I took. A week later my stomach pains had not reduced and I went back to the same doctor, who checked me again and gave me more medicine. While I was leaving the hospital, I met another doctor who asked me what the problem was. I told him that the medicine that Dr. Alex had prescribed to me the previous week had not worked so I had come back. He looked at my medical notes and told me that the medicine was not good enough and I needed an injection. He took me to a separate room for it and told me to come back after two days.

This injection made me vomit and after three days when I came back he gave me yet another injection which he said will stop the vomiting. This medicine made me uncomfortable and I felt a lot of pain and I cried. Soon, I became disoriented, then unconscious. I was recovering my consciousness when I realised that the doctor was naked and forcing himself onto me. I made an alarm but my voice was not loud enough. Someone eventually heard and came and found the doctor naked and the doctor ran away. My mother was called and she came immediately.

I was taken to a police station where I made a statement and was taken for a medical check-up. The check-up found sperm in me but determined that I was not pregnant at that moment. I waited for my menstrual periods in vain and I started worrying. My mother took me for another check-up and this time found that I was pregnant. We reported this to police and despite their investigations they said that the doctor had absconded.

I got pregnant because I had been raped and I decided that I did not want the pregnancy and I wanted to abort. I did not want anyone to know about my decision so I told only my mother and no one else. I only worried about the price it would take to carry out the abortion. We had been told that abortion would lead to death, but I was not worried about this once I had made my decision.

When I went for the abortion the doctor asked me how pregnant I was and I told him. He asked me what I wanted him to do, and I told him. He then took me to another room where there was a female nurse. They told me not to scream because we were near a police station.

After the abortion, the doctor told me that I would feel pain for the next two and a half weeks but then my periods would come. By the time I got home, I was bleeding and feeling a lot of pain but the pain eventually went away.

Complications arising from unsafe abortions

Criminalisation of abortion can lead to an increase in the incidence and prevalence of unsafe abortions.¹¹ Blocking women from safe abortion services means that women who have resolved to terminate their pregnancies will access the same clandestinely and often using unsafe methods.

The Ministry of Health has found that unsafe abortions contribute to 26% of all maternal deaths in Uganda and even more women suffer from severe injuries.¹² It has also been shown that in a particular year 15 out of every 1000 women of reproductive age were treated for complications arising from unsafe abortions.¹³ The number of women experiencing complications from abortion is likely much higher since many may not seek care because they either do not know where to access the treatment or because they fear being harassed by health care providers.¹⁴

In 2008, Esther Nagudi (pseudonym), then only 13 years old, was impregnated by her boyfriend who later denied responsibility for the pregnancy. Frustrated and afraid to face her parents, she resolved to terminate her pregnancy by whatever means. She sought an unsafe abortion from a quack health provider and this led to severe bleeding which she has been living with for eight years now. She had no idea where to go for post-abortion care as she lived in fear of being found out. She therefore went from one herbalist to another in an unsuccessful bid to treat her bleeding. It was only after she met the interviewer that she was able to obtain professional help to treat the complication.

Teenage pregnancy is still widely shunned in Uganda and girls who get pregnant always find themselves having to deal with stigma from their peers at school and from their parents who at times marry them off to the person who is responsible for the pregnancy. In addition to dealing with the physical and health effects of their pregnancies, teenage girls have to deal with rejection from their parents,

their spouses, expulsion from home and school and rebuke from the community.¹⁵ In many instances, the fear of facing these socio-cultural consequences of teenage pregnancies compels girls to seek abortion services often involving unsafe health conditions and unqualified personnel.¹⁶

There is also a lack of information regarding access to contraceptive services and commodities which is important for the prevention of unwanted pregnancies. While people are generally knowledgeable on various methods of contraception, the lack of information on how to physically access the services and the several misconceptions are key barriers to accessing family planning services.¹⁷ In the case of Mirembe Sylvia, she was afraid to use condoms because she was afraid of the side effects of using them due to widespread misconceptions and misinformation on contraception.

Other barriers in accessing contraceptive services in Uganda include: limited range of contraceptive methods available, limited provider skills/ competence to provide some contraceptive methods, requiring young people to receive parental consent prior to accessing family planning services, lack of youth-friendly spaces for accessing family planning services and poor management of side effects of contraception.¹⁸

Limited information on access to contraceptive services contributes to unwanted pregnancies. In the absence of comprehensive abortion care services; unwanted pregnancies lead to an increase in the rate of unsafe abortions, which are a major contributor to maternal mortality in Uganda.



Nagudi Esther, 20, Manafwa District

In 2008, I had a boyfriend who showed me a lot of love and care. I was only 13 years old and in Primary Six. He kept asking me for sex but I refused because I was not ready. Eventually, I gave in. We only had sex once and I got pregnant.

I began suspecting that something was not right when I started feeling cold and lost appetite. I vomited whenever I smelt food. I decided to go to a clinic to see what the problem was and that is where I was tested and informed that I was pregnant. When I went back home, I did not tell my parents because they are tough and would be very angry with me.

I told my friend about it and asked for advice. She told me she had been in a similar situation and had an abortion. I took a month before making a decision to abort. During this period I was really stressed and my boyfriend had started avoiding me, denying responsibility for the pregnancy. If my parents found out that I was pregnant they would have killed me, so I decided to have an abortion because I had no one to help me if I kept the pregnancy.

My friend took me to an elderly woman who told me to find cassava stick. She peeled off the outer layer of the stick and told me to lie down on my back and raise my legs. She then pushed the stick inside me and when she pulled it out blood came with it but nothing else came out. She told me to go home and that everything would be fine. She told me that if after three days nothing had come out I should come back to her.

After three days nothing had come out so I went back to her. This time she brought a basin with water and soap. She gave me some herbs and told me to chew them. They were very bitter. After chewing those herbs she again pushed the cassava stick in me and this time she pushed it really hard and I felt a lot of pain in my abdomen. I started crying and felt like screaming and told her that I could not handle it but she told me not to shout or we could attract attention.

After she brought out the stick, she told me to go home and I went with a lot of pain. I could not even sit down as I was feeling too much pain. I asked my mum if I could go and visit my grandfather because I did not want her to detect what was going on.

By the time I reached my grandfather's house, I was bleeding a lot and the blood was coming with a lot of clots and I was feeling a lot of pain. I eventually fainted.

My grandfather called a local herbalist who gave me some medicine to stop the bleeding and the bleeding stopped but the pain did not go away.

My grandfather kept my secret and even when my mother visited him the following day and asked that I go back home, he told her that my period started and I was feeling pain but he would send me back once the period had passed. I often spend a lot of time with my grandfather.

I stayed with my grandfather for 6 months and he kept deflecting inquiries from my parents about what I was doing at his house. Because of poverty at home, my parents did not mind that I was staying with my grandfather as this relieved them of the burden of taking care of me. Over this time the blood never stopped coming and my periods resumed normally three months after the abortion. I would however have continuous periods, which would not stop until I drank Septrin and Chloroquine. My friend was the one who advised me to take Septrin and Chloroquine to stop the bleeding. The bleeding would only stop for two days then start again after two days.

Three years after the abortion, I told another friend of mine about the problem and she referred me to some man who could help. The man gave me herbs that he said would help me wash away the complications I was suffering from. I took the herbs after which the blood flow increased and it started coming with blood clots again. When I told him that, he encouraged me to take the herbs continuously because they were cleansing my uterus of infections that had remained after the abortion. Unfortunately the more I took the herbs, the more I bled and the more pain I felt. This continued for two months after which I just stopped taking them.

When I stopped them he gave me some other herbs to help me clean my uterus and stop the bleeding and I drank these herbs for a whole year. Even with those herbs there was no change in my condition so I decided to stop taking them. The blood and clots continued, but the pain had reduced.

Throughout this time, the blood would begin flowing at my slightest action—like standing or even coughing or laughing. Sanitary pads would not help because I would use up a whole packet just within an hour. I started stuffing myself with clothes to make sure that the blood didn't spill out. In 2013, an old man who is a friend of mine told me about other herbs that I could use to stop the bleeding. I tried out those herbs and they reduced the bleeding a bit. Eight years have gone by and the bleeding still comes. I still take these herbs.



Mirembe Sylvia , 18, Kiboga District)

At 15 years old, I fell in love with a boy and we waited for some good time before we indulged in sexual activities. When he asked for sex, I did not hesitate. I accepted and we agreed that we would use a condom. It was the first time for each of us, and we did not know how to use a condom. After sex, I felt a lot of pain. There was blood all over me. I started crying and did not know what to do. I checked the condom to find out if it also had blood on it. Indeed it had blood on it and was damaged. It had a hole. My boyfriend told me to keep quiet about it and I never saw him again. When I went to his house, I was told he had been taken to Kampala (the capital city) to study.

After about two months I felt uneasy, had stomach pains, was very sensitive to any perfumes, and had headaches. I feared talking to my mom. However, I talked to an old woman who is a close friend. She confirmed that I was pregnant by using a urinary test. I asked her to help me get an abortion since I was afraid to tell my parents.

She took me to the bush, mixed in water a local herb that she told me it was called “nanda” and told me that I should drink it while she was away. She cautioned me never to tell anyone and she left me there. I had to make a firm decision on whether to take it or not. I thought about my family and feared death, but I also feared telling my parents that I was pregnant. I took the local herbs.

I went back home, and after about three hours I started bleeding. It was uncontrollable and—out of fear—I called my mother. Thinking they were menstrual periods, she took me to hospital. After a check-up, the doctor called us into a room. While there, I became dizzy and passed out. I stayed in hospital for two weeks. My parents were not pleased when they found out what I had done. I was later notified that I would not go back to school because I was a “spoilt girl”. My parents had decided that I would be married off.

While in hospital, I was counseled about family planning and use of condoms but after my experience, I am afraid to use any of those methods. I encourage girls out there to be cautious about their lives. They should abstain from sex or seek counseling services before indulging in sex. Education on condom use is key.

I spent a whole year out of school. During this time, I became a subject of gossip and people badmouthed me for being an undisciplined child with bad manners. I pleaded with my parents to take me back and not force me to become married until they accepted on the condition that I repeat a class to make up for the year of school I missed.



Dr. Kadaga Henry Francis Obstetrician Gynaecologist

Hoima Regional Referral Hospital

I am a civil servant attached to Hoima Regional Referral Hospital as a Medical Officer and I have a Masters in Obstetrics and Gynaecology. On Monday, March 17, 2014, at around 2 pm I got a call from a colleague who told me that he had a complicated case he was handling that needed my intervention. He brought the patient to the clinic in a vehicle. The patient arrived literally dripping blood on the way into the clinic and they went straight to the theatre.

I carried out an ultrasound and confirmed that the patient had blood in her abdomen and was in a lot of pain—bleeding and walking with difficulty. I took blood samples for grouping and cross-matching and found that she was of blood group A-, a very rare type. We were able to secure some blood from Mukono so we decided to enter the theatre. There was a lady who came with the patient and said that she was the patient's sister so she signed surgical consent forms for the operation to be conducted.

I opened the abdomen and found a lot of clotted blood, about 2-3 litres, a perforated uterus especially in the lower part, and heavy bleeding. I tried to stop the bleeding but I couldn't, so I called in the patient's sister and asked for written consent to remove the uterus, as it is the only way we could stop the bleeding. When she consented, I removed the uterus and achieved homeostasis, tied off the bleeding vessels, and the bleeding stopped. I kept her in the theatre for about an hour trying to resuscitate her because she had bled a lot and her blood pressure and oxygen levels were not stable. She recovered and started talking, but the relatives became very anxious and started demanding that we give them the patient to take to another hospital and to give them a referral. Then I told them I could not refer the patient because we needed more blood before she could be moved.

They called the Assistant Inspector of Mulago Police and demanded that we hand over the patient. I refused and explained to the inspector that the patient wasn't stable and we needed more blood for her. We had transfused about 3-4 units of blood but the patient had bled a lot which had led to haemorrhagic shock to the extent that

the internal organs were damaged. They understood the condition and they became calm. I sent for more blood and got more units. We tried our best to save her, but she did not make it. At around 5am or 6am she unfortunately breathed her last breath and died.

When the lady I was trying to provide post-abortion care to died, two plainclothes policemen came and arrested me.

I was arrested together with my midwife. She was on duty with me and helping me out. On reaching Wandegeya police post the investigating team called me and asked me why I was not cooperating with them. They thought I was the one who was involved in performing the initial abortion not knowing that I was just providing post-abortion care. I told them the truth and directed them to where I put the specimens I had removed from her to corroborate my evidence. We drove back to the clinic and they picked up the specimens. I was later asked to make a statement, which I did. I was detained for over two weeks with no case proffered against me.

The case moved around a lot while they tried to look for charges to proffer on me. My file was called to the Kibuli police station then sent back to the Wandegeya police station, and then it went to the state house. But nothing could be done to me because it was confirmed that I was trying to save the woman's life and the procedure had been correctly done. I was not even arraigned to be charged before a magistrate.

The ordeal was psychologically traumatising for me and my staff at the clinic. The implications and impact of that ordeal are still ongoing as there was a catastrophic drop in the number of patients at my clinic as a result of the way the media handled the story. Today when a patient comes to my clinic they are told, "you are going to that clinic where they killed a woman." So the clinic has been seriously stigmatised.

The Experience of Nurse Favour Nabirye

As narrated by her work colleagues, with her permission

Nurse Favour Nabirye (pseudonym) was on night duty at Mulago Medical Center and reported to the clinic at 7pm as she does every other day. She found Dr. Kadaga performing post-abortion care on a patient. She worked with the doctor throughout the night, helping him attend to the patient as well as trying to calm down the attendants who had come with the patient.

At around 11pm, a police man came to the clinic and found the patient in the theatre recovering and while the relatives were demanding that the patient be taken away from the clinic. The policeman understood that the patient was weak and recovering and couldn't be taken anywhere in her current state.

However, the patient passed away, and two plainclothes policemen came to the clinic at 6pm and arrested Nurse Favour and Dr. Kadaga. They were followed by a pick-up truck full of policemen who immediately surrounded the premises and started conducting investigations and collecting evidence. Nurse Favour and Dr. Kadaga were taken to Kapapali police post in Mulago, then later taken to the Mulago police station and then the Wandegeya police station where they were kept in detention. While in detention, Nurse Favour was absolutely terrified, could not eat, and kept crying endlessly. She was released after six days.

Once released, she was so traumatised that she took two months leave to rest and recover from the ordeal. When she returned she refused to be associated with any patient involving post-abortion care and would disappear from the clinic every time a patient requiring post-abortion care came to the facility. One time the clinic received a patient requiring post-abortion care, and Nurse Favour, not wanting to be associated with it, locked herself in the toilet for up to an hour until the patient

had been worked on and had left. She continued to suffer from post-traumatic stress disorder and suffered continuous sleepless nights, a loss in concentration, and would very often be found isolated and crying to herself.

She continues to live through the trauma and stress of her ordeal and has since left the clinic. She now works at a pharmacy as a dispenser where she feels safer and will not be exposed to such an ordeal again.

Medical options for accessing safe abortions in Uganda

In spite of the restrictive legal environment in Uganda, the health system has the capacity to provide safe abortion services to women who need them. However, these services are not readily available to the girls and women who need them.

The legal defence in the Penal Code Act only excuses a termination of a pregnancy from criminal liability where it is performed with reasonable care and skill by a surgical operation (Section 224, Penal Code Act). It can be argued that the Penal Code's limitation to surgical operation was conceived in a health setting in which termination of pregnancy was only possible by way of surgical operation. Advancements in science and technology render this language unnecessarily limiting to the use of contemporary methods which do not require surgery and are safe. World Health Organisation (WHO) recommends medical abortion through use of mifepristone and misoprostol to terminate pregnancies up to 12 weeks.¹⁹

The 2012 National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights similarly recognize advancement in medicine and technology for termination of pregnancy; they provide for the facilities at which termination of pregnancy can be carried out and the cadres of health workers who can perform them. Termination of pregnancy by medical induction can be carried out at health units at referral level (Health Centre IVs and above).²⁰

Health workers at the cadre of nurse/midwife, clinical officer, medical officer and obstetrician/gynaecologist can terminate pregnancies by way of medical induction and evacuate incomplete abortions while only health workers at the cadre of the obstetrician/gynaecologist can terminate pregnancies by way of surgical induction.²¹

There is therefore a contradiction between the policy space that prescribes for the ability of nurses, midwives, clinical officers and medical officers to terminate pregnancies through medical induction and the legal environment which only permits termination through surgical induction which in this case can only be conducted by Obstetrician/Gynaecologists.

In a setting like Uganda, where human resources are constrained, it is only reasonable that skilled and trained mid-level health workers be permitted to provide lawful and safe medical abortions.. A skilled health professional in this case would be any person who has appropriate skill in termination of pregnancy and is competent in providing this service, including a medical doctor, clinical officer, or midwife.

The challenge of providing safe abortion services, however, goes beyond the legal and policy provisions. It is also affected by factors including ignorance of the law and policy, cultural and religious influences leading to conscientious objections, and fear of stigmatisation at the hands of health workers.



Dr. Kiggundu Charles

Consultant Obstetrician Gynaecologist, Mulago Hospital

Mulago Hospital has a very busy maternal clinic. It delivers between 33,000 to 35,000 babies every year, which is close to 100 deliveries per day. We probably have about 150 maternity patients per day. For abortions we have about 10,000 per year. It is such a big figure. Women who have terminated pregnancies are assessed and treated accordingly. We then counsel them and tell them about contraception and safe sex.

The perceptions on abortion have progressively changed over the 20 years I have been in practice. Junior colleagues perceptions are more progressive among the. Some doctors used to be referred to as “abortion doctors” because they provided abortion care but there is gradual change in the ward. There is however a problem of sustaining the midwives and nurses who have developed positive attitudes towards abortion. The midwives and nurses who have been trained are continuously being transferred and taken to other wards yet the attitude takes time to change. This has greatly impacted the provision of abortion and post-abortion care in the hospital.

Women are responsible people and can make sound decisions on termination of pregnancy. The biggest barrier to accessing abortion is access to the service itself. Not every health centre provides abortion care. Some hospitals don't have the facilities, others the training, and others the staff. Others may have all that in place but require a woman to fill in a police form before they can access the service. Practically no woman will agree to complete a police form because of the limitation of the law in the country.

The other barrier is socio-religious circumstances. There is a hospital in Kampala that had doctors and nurses and specialists who provided quality abortion care. They would see a patient in 30 minutes, take her to the theatre, give her post- abortion care, treat her, and discharge her the following day.

But there was a case of a hospital secretary who had an incomplete abortion. She sought medical care at the hospital. The medical consultant left her unattended to for

three days. When she was attended to, she was treated without anaesthesia because the health care workers wanted her to feel the pain of what she had done. Then she was discharged both from the hospital and from her job.

Although the Ministry of Health has policies, standards, and guidelines that should be applied by all health facilities while providing abortion and post- abortion care services, this does not always happen. Even Mulago, the national referral hospital, does not employ these policies, although we have protocols on management of abortion and management of sexual violence.

I know that Ugandan law punishes unlawful termination of pregnancy. The Penal Code Act, which we look at as the law in place, penalises unlawful termination and it penalises providers, suppliers, and women. I know that a lawful abortion is done in good faith. We have been doing this for a long time.

The policy on abortion was not clear until about 2006 when the Ministry of Health pronounced itself on circumstances in which safe termination is allowed but the policy document is not exhaustive. The 2012 guidelines did not change much what was in the 2006 guidelines but the problem is that it isn't clear whether the policies are legally enforceable.

Doctors are not required to report abortions. They are sworn to confidentiality, and even when discussing it they remove the identifiers of the patients. At times the police and state prosecutors threaten the health workers so they succumb and disclose the information. Because of their oaths, health workers should be obliged to protect the confidentiality of their clients.

I know about five doctors who have been arrested and some of them I have read in the papers. The police don't differentiate between abortion and post- abortion care, so they arrest them as the same—and yet post-abortion care is not criminalized.



Enforcing the law on abortion in Uganda

The law on abortion in Uganda remains too complicated for the authorities to enforce. While the High Court of Uganda has unlimited jurisdiction in all offences there are offences that have been left to the jurisdiction of the Magistrates' Court and will therefore only be heard by the High Court when exercising its appellate jurisdiction.

Under the Magistrates Courts, the Chief Magistrates can try all of the offences relating to abortion since they are empowered to try all offences, save for offences whose punishment is death.²² The Magistrates Grade 1 can try cases of attempt to procure a miscarriage under Section 141, procuring a miscarriage under Section 142 and supplying drugs to procure a miscarriage under Section 143.²³

In the Magistrates Courts, offences are prosecuted by the Director of Public Prosecutions (DPP), who has authority to institute criminal proceedings against any person on behalf of the State.²⁴ In addition to instructing the police to investigate any matter, the DPP usually acts on the arrests and investigations of the police who are mandated to preserve law and order and prevent and detect crime.²⁵

One of the strongest limitations of the law on abortion in Uganda is that it remains stuck in the criminalisation perspective and has not developed to appreciate the rights of women, yet the country is signatory to international human rights treaties and instruments that recognize the reproductive rights of women including access to comprehensive abortion care.

Article 12 of the International Covenant on Economic Social and Cultural Rights recognizes the “right of everyone to the enjoyment of the highest standard of physical and mental health”. This right includes “the right to control one’s health and body, including sexual and reproductive freedom,” which “requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health”.²⁶

The Convention on Elimination of all forms of Discrimination against Women under Article 12 requires Uganda to eliminate discrimination against women in their access to health-care services throughout their life cycle, particularly in the areas of family

planning, pregnancy and confinement and during the post-natal period.

This obligation requires the state to among others “prioritize the prevention of unwanted pregnancy through family planning and sex education and reduce maternal mortality rates” and when possible, amend legislation criminalizing abortion “to withdraw punitive measures imposed on women who undergo abortion”²⁷.

The African Charter on Human and Peoples' Rights under Article 16 also provides for the “right to enjoy the best attainable state of physical and mental health”. Towards the fulfilment of this right, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) under Article 14 (c) requires the state to authorize abortion in cases of sexual assault, rape, incest, and when continued pregnancy endangers the mental and physical health or life of the women or the foetus. Uganda has however reserved on the application of Article 14 (c) of the Maputo Protocol.

Despite this, it has received recommendations from human rights mechanisms to ensure access to legal abortion including recent recommendations from the United Nations Committee on Economic, Social and Cultural Rights urging it to decriminalize abortion and expand the circumstances under which services are made legal and available.

These provisions have been incorporated into the Constitution, which requires the state to “provide the facilities and opportunities necessary to enhance the welfare of women to enable them to realise their full potential and advancement” and to “protect women and their rights, taking into account their unique status and natural maternal functions in society”.²⁸

Despite these well documented human rights of women in Uganda, the enforcement of the law on abortion has been limited to the criminal perspective ignoring the obligation the state has in enforcing the reproductive health rights of women.



Experience of a Police Officer

In Charge of Homicides, Kampala

We normally receive complaints from the Local Council Chairman (LC) of the area regarding likely abortions. In some of these instances you find that the woman is not known and we end up closing the cases. In cases where we find the woman, we take her to court and prosecute her. We usually seek advice from the resident state attorney on what to do with the file.

When we arrest the woman and she is willing to lead us to the man responsible for the terminated pregnancy we charge both of them. The man is charged with aiding and abetting or procuring an abortion because in most cases it is the man who gives the woman money to get the abortion because they don't want the pregnancy. If the woman reveals the clinic she went to, we also arrest the nurses and charge them for procuring abortion. The problem is that these women may take you to a place or a clinic and they fail to identify the specific nurse, so the nurses are usually very difficult to get. We usually start our investigations after getting the woman.

For a person to be allowed to terminate a pregnancy, that one depends on the advice of a doctor because most of these people at times they don't seek advice first. A person just says I want this pregnancy out. If it is on medical grounds I think that one is justifiable.

Usually when it comes to the time of the defence, the women come with a very strong defence for example they say the foetus came out on its own. We don't have mechanisms to prove whether the abortion is because of the medicine taken by the woman or not yet you find somebody could have used some drugs. At times the Court cautions them when they find them guilty. They say they were may be sick or had other problems that made them abort so Court just cautions them.

A police officer at a community dialogue on unsafe abortions in Manafwa district.



Roles of the local communities in enforcement of the law on abortion

The communities in which girls and women live play a significant role in the prosecution of cases relating to abortion. When a girl gets pregnant, her first point of call is either a close and trusted family member or a neighbor in the local community.

Given the very limited knowledge of the law and policy on abortion across most communities in Uganda, girls who should be able to access legal abortion are not provided that option. This leaves them at the mercy of clandestine and unsafe abortions.

The local council leaders play both an administrative and policing role in the communities. They are usually closer to the community members than the local police since they are more approachable and have been democratically elected by the community.²⁹ When there is any complaint relating to an abortion that has been performed in the area, the complaint is usually made to the local council leaders and not necessarily the police.

With the limited knowledge on the law and policy on abortion in Uganda, such complaints can be used as examples to warn girls who may be contemplating termination of pregnancies. Unfortunately this can only increase the social stigma for girls or women, which can drive them to access unsafe abortions.

When local leaders are faced with decisions regarding how to handle cases of abortion in their communities, they are often driven by values and beliefs of the socio-cultural setting in which they operate. In the case of Milly Nassuna below, it did not matter that she had a mental disability and had been defiled. When her case was presented to the local leaders, they ignored the circumstances of her case and sided with the community mob so as to make an example of Milly's situation.

When local leaders do not have access to information regarding reproductive health services and rights guarantees, and the law on abortion, girls who become pregnant within those communities have very little opportunity for access to justice even when they meet the legal indications for abortion such as when they have been sexually violated. Just like in the case of Milly, women can be unfairly subjected to criminal trial resulting in conviction and injustice.

Ms. Namatovu Gorreti and Mr. Wasswa Alex are two local leaders who have addressed local complaints relating to abortion.



Namatovu Gorreti

Secretary for Women Affairs LC1, Gwaffu Village

I am a female resident of Gwaffu Village and the Secretary for Women Affairs. I do not support abortions and I usually counsel couples on the dangers of abortion. Women mostly abort because their men force them to. The majority of the men do not give women the necessary care and financial support during pregnancy. For example one of my very own, Nassuna Milly (I am her guardian now), aborted and she was imprisoned. Had the man done his job and provided her with the necessary care, she wouldn't have aborted. I suggest that the men should also be imprisoned. The law shouldn't only punish women that abort but also men that impregnate them and lead to such abortions. They shouldn't be above the law. This will deliver a message to others and we could stop girls.

What I know is that if a woman decides to abort, she will do so, but as leaders we need to work hand in hand with organizations and other officials to sensitize communities on the dangers of unsafe abortion. It would be great if family planning methods such as injecta plan, pills, condoms, etc., were provided to the public to avoid unwanted pregnancies that may lead to abortions.



Wasswa Alex

Local Council 1 Chairman, Gwaffu Village

WHEN I was informed that Nassuna Milly aborted, I had to call in police to calm the communities that had ganged around her, but also to show her that what she had done deserved a punishment. What I did pleased the communities because Milly showed a bad example to other girls in the community. The reaction created fear and I bet no other girl would commit an abortion. This does not mean that others weren't angry. It is very difficult to please people. Milly's relatives have never been happy with me.

What I know is that when a woman or girl decides to abort, she will abort. We tried as the community to look after this particular girl by providing the basics. There was no need for her to abort, but she did.

My preference is that communities are trained and provided with modern family planning methods as a way of preventing unwanted pregnancies that lead to abortions. My community has not received this. We still struggle and have had one of them abort and serve a sentence in prison.

Defending people accused of offences relating to abortion

Every person accused of an offence in Uganda has rights to ensure that they get a fair trial. These rights include the right to a presumption of innocence, the right to be given adequate time and facilities to prepare one's defence, and the right to be afforded facilities to examine witnesses and obtain attendance of other witnesses before Court.³⁰

These rights, however, can be very difficult in a society where suspects and the accused themselves are not sure of the law, and the state agencies narrowly interpret the law. This is exacerbated by a society that stigmatises any girl or woman who needs to access safe abortion services.

When people are arrested or accused of offences relating to abortion, very little regard, if any, is paid to the protection of their rights, and very few people are similarly willing to stand up in defence of their rights.

The Constitution of the Republic of Uganda entitles a person charged with a criminal offence to be permitted adequate time and facilities for the preparation of his or her defence and in cases where he or she is charged with an offence punishable by death or life imprisonment, he or she is entitled to legal representation at the expense of the State (Article 28 (3)). Abortion related offences neither attract punishments of death or life imprisonment and this means that women or girls charged with such offences have to bear the cost of legal representation on their own which in most cases they are unable to do. The unfortunate yet preventable outcome is that in many instances, these women are forced to represent themselves in court without the requisite legal skills needed to make their case regarding whether they had an induced or spontaneous abortion, and, if induced, whether the grounds provided under the penal code or the 2012 Standards and Guidelines were applicable.

Nassuna Milly, who suffers from a mental disability, was impregnated by a man who denied responsibility for the child. She was forced into an unsafe abortion. Unfortunately, her abortion was discovered by the community members, and she was arrested. Without legal guidance of any sort, she was harassed by police until she conceded to the charges, and was later convicted. She served a sentence of five months. No regard was paid to her mental state or her right to receive legal guidance.



Nassuna Milly

I lost both my parents and went to stay with an elderly woman. While there, I got pregnant by a boda-boda rider (motorcyclist). When I told him I was pregnant, he refused to look after me or provide me with the basics to carry on the pregnancy. Worst of all, he denied being responsible for the pregnancy. One day I decided to use a herb, called “nanda,” and successfully aborted.

But because I used to get food and basic necessities from well-wishers at the village, it came to their notice that I was not pregnant anymore. They ganged around me and invited community people to beat me up. They rushed to the LC1 chairperson to report me and he called in police. When police came, they threw me into their car and drove me to Kawuga prison. I was later charged with the offence of procuring an abortion.

While in prison, I was called in court on several occasions to have my case heard. At each court hearing I was told that there were investigations still going on and that I should go back to Kawuga prison. This happened more than five times. While in prison, I was advised by the prison warden that the offence I had committed attracted a big sentence of seven years imprisonment but cautioned that if I accepted the offence, the court would side with me since I would have saved its time. At the next hearing, when the charge was read to me I pleaded guilty and asked for forgiveness. No witness came to implicate me. I was given a sentence of imprisonment for seven months but I only served five months and I was released. I told the court that I aborted because my condition was bad, but I was not given a chance to explain this condition. I had no lawyer and the questions asked by the prosecutor required a yes or no answer.

I learned a lot in prison. The prison warden counselled all female inmates on issues of family planning and abortion. There were many people who had committed the same offence in prison.

Kirumira Allan

Legal Advisor, Uganda Private Midwives Association (UPMA)

I work with the Uganda Private Midwives Association (UPMA) as the legal advisor. Specifically, I help the organisation on matters pertaining to the law and support them in the issues they find at their clinics to make sure that the services they provide are in consonance with the law.

The law as it is right now is to discourage abortion and to punish offenders. The problem has always been that it is not clear to the law enforcers how it should be enforced. The boundaries of the law are not clear, so in most cases you find that the health workers are the victims.

The police will always go after the health workers not knowing that in most cases the health workers are providing post-abortion care. A number of cases have gone to court, but we find that it is in situations where the women died that the cases go to court, because the relatives push for prosecution.

The prosecutions of abortion cases have been limited because to ensure a successful prosecution, there has to be someone pushing for it. Those who push for it are usually the relatives of the woman who has died. but you find that where the relatives of the woman are supportive of the abortion, they will not push for prosecution.

The prosecution system is such that sometimes the police may want to take advantage of the law and get someone pushed to the wall so as to harass them to get something (financial) out of them. It is hard to generalise the perceptions of judges on cases relating to abortion because every case presents differently, and depending on the case you are likely to get a different outcome from the court. Generally speaking, they try to apply the law as it is. but of course the jurisprudence has been a bit sketchy because the law is quite unclear.

The law is designed to prevent and punish a practice, but I think that is being done in the wrong way. We need to examine the real problem and get the right cure for that problem. The real problem in as far as I am concerned is the consequences because the causes of abortion will always be there. The law should be looking at this person with the problem and how she manages that problem. Our role has been to sensitise people on the difficulty that health workers go through while managing their clinics. A woman is coming into the center and is for instance bleeding. That person cannot be refused access to service.

Recommendations

To Parliament

- Enact the law envisaged under Article 22 (2) of the Constitution to clearly provide for the circumstances under which women and girls should have access to safe and legal abortion.
- Expand the legal indications for abortion in recognition of women's and girls' experiences and in compliance with human rights provisions guaranteed in the Constitution and in regional and international human rights instruments.

To the executive/cabinet.

- Develop and implement nation-wide sensitisation and awareness- raising campaigns on the legal framework of abortion in Uganda to address lack of information and misperceptions by women and girls, communities, healthcare providers, and law enforcement among others, regarding access to and provision of safe abortion services and to ensure the rights of women who receive abortion services and the healthcare workers who provide them, are protected.

To the Judiciary

- Provide clear interpretations of the abortion law which recognize the rights guarantees under the Constitution and comply with regional and international human rights norms and standards with respect to women's and girls' access to safe abortion.

To law enforcement agencies.

- Ensure police and other relevant law enforcement officials receive sufficient training on the abortion law and Uganda's human rights obligations, as well as appropriate investigative and interrogatory practices, to eliminate unwarranted arrests, detention, and prosecution of women, girls, and healthcare providers for abortion- related services.

Endnotes

1. WHO.(2015). World Health Statistics. Geneva: World Health Organisation.
2. Ministry of Health. (2014). *The Annual Health Sector Performance Report 2013/2014*. Kampala: Republic of Uganda .
3. Ministry of Health. (2012). *The National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights*. Kampala: Republic of Uganda
4. The Ministry of Health. (April 2015). *The National Standards and Guidelines for reducing Maternal Morbidity and Mortality from Unsafe Abortion in Uganda*. Kampala: Government of Uganda
5. The Cabinet Secretariat. (2012). *The Cabinet Handbook*. Kampala: Republic of Uganda.
6. Ibid
7. Ministry of Health.(2012). 2.2.5.*The National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights*. Kampala: Republic of Uganda.
8. Ibid
9. Ministry of Health .(2006). *National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights*. Kampala: Ministry of Health.
10. Ministry of Health.(2012). 2.2.5.*The National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights*. Kampala: Republic of Uganda.
11. Mulumba. M, Hasunira. R, & Nabweteme. F. (2014). *Criminalisation of Abortion and Access to Post Abortion Care in Uganda, Community experiences and perceptions in Manafwa district*. Kampala: CEHURD
12. Guttmacher Institute. (2013). *Factsheet on Abortion*. New York.
13. Singh, S., Prada, E., Mirembe, F., & Kiggundu, C. (2005). *The Incidence of Induced Abortion in Uganda*. New York: Guttmacher Institute.
14. Prada, E., Mirembe, F., Ahmed, F. H., & Kiggundu, C. (2005). *Abortion and Post-abortion Care in Uganda: A report of Health Care professionals and Health Facilities*. New York: Guttmacher Institute.
15. Atuyambe, L., Mirembe, F., Tumwesigye, N. M., Annika, J., Kirumira, E. K., & Faxelid, E. (2008). Adolescent and adult first time mothers' health seeking practices during pregnancy and early motherhood in Wakiso district, central Uganda. *Reproductive Health*, 5:13.
16. Atuyambe, L., Mirembe, F., Johansson, A., Kirumira, E. K., & Faxelid, E. (2005). Experiences of Pregnant Adolescents - Voices from Wakiso District, Uganda. *African Health Sciences*, 304 - 309.
17. Nalwadda, G., Mirembe, F., Byamugisha, J., & Faxelid, E. (2010). Persistent high fertility in Uganda: young people recount obstacles and enabling factors to use of contraceptives. *BMC Public Health*.
18. Nalwadda, G., Mirembe, F., Tumwesigye, N. M., Byamugisha, J., & Faxelid, E. (2011). Constraints and prospects for contraceptive service provision to young people in Uganda: providers' perspectives. *BMC Health Services Research*.
19. World Health Organisation.(2014). *Clinical Practice Handbook for Safe Abortion*. Geneva: WHO.
20. Ministry of Health.(2012). 2.2.5.*The National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights*. Kampala: Republic of Uganda.
21. Ibid
22. Section 161 (1), Magistrates Courts Act Cap. 16, Laws of Uganda
23. Ibid
24. Article 120 (3), Constitution of the Republic of Uganda
25. Article 212, Constitution of the Republic of Uganda
26. CESCR. (2000). *General Comment No 14: The Right to the Highest Attainable Standard of Health (Article 12)*.Office of the High Commissioner for Human Rights.
27. CEDAW. (1999). General Recommendation No. 24: Article 12 of the Convention (Women and Health). *Twentieth Session of the Committee on the Elimination of Discrimination against Women*, (p. A/54/38/Rev.1).
28. Article 33, Constitution of the Republic of Uganda
29. Local Government Act, Cap 243, Laws of Uganda
30. Article 28 (3), Constitution of the Republic of Uganda



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