



CEHURD
social justice in health

VIOLATIONS OF SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN THE ERA OF THE GLOBAL GAG RULE AND COVID-19

An Institutional Position Paper

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SUMMARY

The United States' Mexico City policy, also known as the Global Gag Rule (GGR), has had wide ranging implications for access to sexual and reproductive health and rights (SRHR) in Uganda. The policy prohibits foreign non-governmental organisations (NGOs) that receive United States of America (US) global health assistance from providing legal abortion services or referrals, while also barring advocacy for abortion law reform even if it is done with the NGO's own, non-US funds. With the US Government being the single biggest funder of Uganda's family planning programme, the policy severely disrupted service delivery and access, leading to a surge in unintended pregnancies, unsafe abortions, disability, deaths and rights violations – with the impact being exacerbated by the Coronavirus Disease (Covid-19) pandemic and the ensuing restrictions on movement. While the new Biden Administration repealed the harmful policy soon after assuming office in January 2021, its effects will take a long time to reverse – and some may be irreversible. Findings from a case study of Marie Stopes show that Uganda's largest SRHR service provider had to prematurely close a voucher project for poor women, end partnership with clinics, scale down outreach services, stop support for its flagship Blue Star network of clinics, and cut down staff and staff salaries, in addition to suffering reputational damage. Motivation and morale have waned among clinic proprietors, frontline service providers and clients. Service providers and SRHR advocacy organisations should engage the new US Government for a quick return to normal service delivery and build a movement against a future return of the Global Gag Rule by supporting the enactment of the Global Health Empowerment and Rights Act.

1. BACKGROUND

1.1 Introduction

Center for Health, Human Rights and Development (CEHURD) is an indigenous, non-profit, research and advocacy organisation which is pioneering the enforcement of human rights and the justiciability of the right to health in Eastern Africa. CEHURD was founded in 2007 and is registered under the laws of Uganda as a company limited by guarantee with Uganda Registration Services Bureau and as a non-governmental organisation with the National NGO Registrations Board. It was formed to contribute towards ensuring that laws and policies are used as principal tools for the promotion and protection of health and human rights of populations in Uganda and in the East African region.

CEHURD's strategy involves deconstructing health and human rights and use of the law, ground-breaking public interest litigation and policy engagements, including evidence-based advocacy and community mobilisation as the major entry points that informs its interventions at national level. We focus on issues where there are significant gaps in the right to health, such as access to medicines, expanding reproductive and maternal health and rights, including youth-friendly services, and addressing underlying determinants of health including access to a clean and healthy environment, water and sanitation, education, food and housing. We have worked on HIV and AIDS, tuberculosis, gender-based violence, and more.

One of the main issues of concern is the poor attention given to women, particularly mothers. It is saddening that health indicators, especially related to women, continue to paint a worrying picture. For instance, the maternal mortality rate is estimated at 336 in 100,000 live births, and up to 26 per cent of these deaths occur due to unsafe abortion – a condition that is both preventable and manageable. In 2012, CEHURD mobilised like-minded civil society organisations (CSO) and service providers to form the Coalition to Stop Maternal Mortality due to Unsafe Abortion (CSMMUA), with CEHURD as host and coordinator. CSMMUA brought together civil society and community-based organisations (CBOs), as well as practitioners and professional bodies, to advocate for increased access to safe

and legal abortion. CSMMUA is the largest body in Uganda advocating for an end to the deaths that result from unsafe abortions, and the variety of groups participating in its activities demonstrates the breadth of organisations that find value in this advocacy. As an organisation and as a part of this coalition, CEHURD has experienced the direct impact of the Global Gag Rule, in addition to having to speak up on the reproductive rights of women in a legal environment that is restrictive of abortion.

This paper has been produced as an institutional position paper and follows our ongoing research and advocacy on the US Global Gag Rule and its effects on sexual and reproductive health and rights (SRHR) in Uganda and the rest of the Global South. The ideas represented here were developed in conversation with many of CEHURD's partners and coalitions, including members of CSMMUA, the Right Here Right Now (RHRN) platform, and the Get Up Speak Out for youth rights (GUSO) programme partners. It further draws on research findings from a case study of the impact of the Global Gag Rule on the provision and access to SRHR services provided by Marie Stopes, Uganda's largest provider of family planning services. The paper expounds on CEHURD's rationale for advocating against the controversial policy and is intended to inform the campaign for mitigating the long-term impacts of the harmful policy and as part of building a movement against the policy's future return.

1.2 Uganda's SRHR needs

Uganda registered improvements in some SRHR indicators between the 2011 and 2016 national demographic and health surveys, however, the overall SRHR situation remains poor. The country has one of the youngest and fastest growing populations in the world.¹ The national population is estimated to have reached 40.3 million people in mid-2019,² and will reach 56 million by 2025. According to the 2016 Uganda Demographic and Health Survey (UDHS), the total fertility rate was estimated at 5.4 children per woman. The teenage pregnancy rate is among the highest in sub-Saharan Africa, estimated at about 25 per cent. The annual population growth rate between 2002 and 2014 censuses was estimated at 3.03 per cent, making Uganda the nation with one of the world's highest population growth rates. As a result, the majority of the population is young; up to 55 per cent of the population is below 18 years and 75 per cent below the age of 35 years.³

Religious and cultural norms as well as insufficient investment in sexual and reproductive health impact access to services and information.⁴ In addition, informing women about available contraceptive options and distributing supplies remain huge challenges. ⁵While contraceptive availability has increased, only 27.3 per cent of Ugandan women use a modern form of contraception, which is still below the average for sub-Saharan Africa, and almost half of sexually active women of reproductive age have an unmet need for modern contraception.⁶

Uganda's maternal mortality ratio (MMR) stands at 336 deaths per 100,000 live births; 26 per cent of these deaths are attributed to unsafe abortion,⁷ well above the average of 239 deaths in developing countries worldwide – eight per cent of these deaths are as a result of unsafe abortions. ⁸The number of women having unsafe abortions has been on the rise, from 294,000 in 2003 to 314,000 in 2013.⁹ In 2013, it was estimated that up to 52 per cent of pregnancies were unplanned and that 314,300 induced abortions occurred, and an estimated 128,682 women were treated for abortion-related complications.¹⁰ Unsafe abortions are one of the leading causes of maternal mortality

1. Uganda Population Council. Uganda state of the population report 2019.

2. UBOS. 2019 statistical abstract

3. Uganda Bureau of Statistics (UBOS). National Housing and Population Census 2014.

4. Expanded, O. T. S., & Rule, G. G. (2018). Uganda.

5. Cleland, J., Harbison, S., & Shah, I. H. (2014). Unmet Need for Contraception: Issues and Challenges. *Studies in Family Planning*, 45(2), 105-122.

6. Ibid.

7. 2016 Uganda Demographic and Health Survey, 2016. Uganda Bureau of Statistics, Kampala, Uganda.

8. <https://www.gutmacher.org/fact-sheet/abortion-and-postabortion-care-uganda#>

9. Guttmacher Institute (2013). Abortion and Postabortion Care in Uganda. <https://www.gutmacher.org/fact-sheet/abortion-and-postabortion-care-uganda>

10. Prada E, Atuyambe LM, Blades NM, Bukonya JN, Orach CG, Bankole A (2016). Incidence of Induced Abortion in Uganda, 2013: New Estimates Since 2003. *PLoS ONE* 11(11): e0165812. <https://doi.org/10.1371/journal.pone.0165812>

and morbidity in Uganda, contributing an estimated 26 per cent to maternal deaths.^{11 12}

The provision of comprehensive abortion care services has been hampered by a restrictive legal environment. The Penal Code legislation criminalises the procurement of abortion except to save the life of the mother, but falls short of comprehensively providing for instances in which abortion may be permitted.¹³ This has resulted in the law being interpreted inconsistently by law enforcement and judicial personnel, leaving medical providers reluctant to perform an abortion for any reason because they are often unsure when it is legal to do so.¹⁴

The Global Gag Rule has in the past been linked to a 40 per cent increase in pregnancy terminations in African countries that depend on US foreign aid, along with a symmetric reduction in use of modern contraception of 13.5 per cent, and an increase in pregnancies of 12 per cent.¹⁵ The impact of the Global Gag Rule has been exacerbated by the outbreak of the Covid-19 pandemic, which together with the poorly-thought out response, has had a significant downstream effect on the accessibility and availability of SRHR services, and indirectly caused morbidity, mortality and SRHR violations.¹⁶

1.3 US contribution to Uganda's SRHR programming

Most of Uganda's reproductive health funding has been attributed to donor support.¹⁷ In the 2013/14 Uganda Health Accounts National Health Expenditure, it was reported that of Uganda's current health expenditure, 40 per cent is out of pocket expenditure, 17 per cent is Government spending, and 41 per cent is financed by development partners, primarily bilateral donors. Of the health financing by development partners, 49 per cent of funds go to preventive care.¹⁸

With Uganda's ever shrinking health budget far below from the 15 per cent target of the Abuja Declaration in 2001,¹⁹ this means that the State's reliance on donors to support health programmes is high. Furthermore, Uganda's health programmes are mainly implemented by non-governmental organisations or partners such as Marie Stopes and International Planned Parenthood Federation through Reproductive Health Uganda,²⁰ amongst others. This consequently means Uganda's dependence on donor support through loans and grants is quite high, leaving basic health services subject to fluctuation in quality, based on the political changes occurring in such countries as the United States.

The US Government is by far the largest international donor to Uganda's family planning programme, contributing up to 90 per cent of all international disbursements in financial year 2016.²¹ Non-US NGOs, who are major recipients of this US funding, play an important role by delivering over half of Uganda's family planning services.²² Hence, any loss

11. Gorrette, N., Nabukera, S., & Salihu, H. M. (2005). The Abortion Paradox in Uganda: Fertility Regulator or Cause of Maternal Mortality. *Journal of Obstetrics and Gynecology*, 25(8), 776-780.

12. Ministry of Health (2014). *The Annual Health Sector Performance Report 2013/2014*.

13. Center for Health, Human Rights and Development (CEHURD) and CRR, (2016). *Facing Uganda's Law on Abortion: Experiences from Women and Service Providers*. <https://bit.ly/2lqY6c8>

14. *Ibid*.

15. Nina Brooks, Eran Bendavid, and Grant Miller (2019). USA Aid Policy and Induced Abortion in Sub-Saharan Africa: an Analysis of the Mexico City Policy. *The Lancet Global Health*, Vol.7 Issue 8, [https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(19\)30267-0/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(19)30267-0/fulltext)

16. UNFPA Uganda (2020). *Right(s) Here: Delivering SRHR under Covid-19*. https://uganda.unfpa.org/sites/default/files/pub-pdf/rights_here_delivering_srhr_under_covid-19_1_0.pdf

17. PAI (2018). *Access denied: Uganda – Preliminary Impacts of Trump's Expanded Global Gag Rule*. *Access-Denied_Uganda_March-2018.pdf*

18. *Uganda Health Accounts National Health Expenditure, 2016*. Ministry of Health.

19. *The Abuja Declaration: Ten Years On*, n.d. World Health Organization.

20. PAI (2018). *Access denied: Uganda – Preliminary Impacts of Trump's Expanded Global Gag Rule*. *Access-Denied_Uganda_March-2018.pdf*

21. FOREIGNASSISTANCE.gov. *Foreign assistance in Uganda*. <https://foreignassistance.gov/explore/country/Uganda>

22. PAI (2018). *Access denied: Uganda – Preliminary Impacts of Trump's Expanded Global Gag Rule*. *Access-Denied_Uganda_March-2018.pdf*

of US Government funding due to the Global Gag Rule places Uganda's family planning programme in a precarious and vulnerable state.²³

Ministry of Health estimated the total funding need for the family planning programme and contraceptive commodities in fiscal year 2017 at \$19.8 million and \$25.5 million, respectively,²⁴ and the Government of Uganda pledged less than 10 per cent of these costs in 2018.²⁵ In 2015, the US contributed a total of \$91.74 million in global health assistance to Uganda.²⁶ The following year, in 2016, the United States obligated over \$227 million to Uganda for health programmes through the US Agency for International Development (USAID). Up to 70 per cent of that amount was funding for HIV/AIDS, family planning, as well as maternal and child health.²⁷

An assessment of the preliminary impacts of the expanded Global Gag Rule conducted by Population Action International (PAI) in 2017 found emerging negative impact on SRHR in terms of increasing commodity insecurity; chilling effects on advocacy for safe abortion and post-abortion care services; the dismantling of referral networks between compliant and noncompliant organisations; heavy administrative burdens for organisations; the disruption of donor coordination; and a bolstering of Ugandan SRHR opponents.²⁸ Even though the Biden Administration rescinded the policy in January 2021, a lot of damage had been done, including loss of critical funding to CSOs, breakdown of health care, and a rise in unintended pregnancies, unsafe abortions and deaths.

1.4 Scope of the Global Gag Rule

The Global Gag Rule has its roots in the Foreign Assistance Act of 1961 which authorised funding, specifically international development funding. In 1973, this law was amended in a provision called 'the Helms Amendment', which prohibited foreign assistance funds from directly being used for the performance of abortion as a method of family planning or to motivate or coerce any person to practise abortions, under Section 104(f)1. These sections provide that:²⁹

1. None of the funds made available to carry out this part may be used to pay for the performance of abortions as a method of family planning or to motivate or coerce any person to practise abortions.
2. None of the funds made available to carry out this part may be used to pay for the performance of involuntary sterilisations as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilisations.
3. None of the funds made available to carry out this part may be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilisation as a means of family planning.

A decade later, at the 1984 International Conference on Population, then US President Ronald Reagan introduced the Mexico City Policy or Global Gag Rule. At this conference, President Reagan stated that the US believed that the population programmes can and must be respectful of religious and cultural values. His statement clearly stated that attempts to use abortion in family planning was to be shunned, whether exercised against families within a society or

23. Giorgio M, Makumbi F, Kibira SPS, Bell S, Anjur-Dietrich S, Sully E (2020). Investigating the Early Impact of the Trump Administration's Global Gag Rule on Sexual and Reproductive Health Service Delivery in Uganda. PLoS ONE 15(4): e0231960. <https://doi.org/10.1371/journal.pone.0231960>

24. Ministry of Health (2014). Uganda Family Planning Costed Implementation Plan 2015-2020.

25. Giorgio M, et. Al (2020).

26. PAI (2018). Access Denied: Uganda Preliminary Impacts of Trump's Expanded Global Gag Rule, 2018. Population Action International, Washington, DC.

27. Center for Health, Human Rights and Development (CEHURD) and CRR, (2016). Facing Uganda's Law on Abortion: Experiences from Women and Service Providers. <https://bit.ly/2IqY6c8>

28. PAI (2018). Access denied: Uganda – Preliminary Impacts of Trump's Expanded Global Gag Rule. Access-Denied_Uganda_March-2018.pdf

29. Foreign Assistance Act of 1961, 1961. <https://legcounsel.house.gov/Comps/Foreign%20Assistance%20Act%20Of%201961.pdf>

against nations within the family of man. President Reagan's statement read, in part:

“...when dealing with nations which support abortion with funds not provided by the United States Government, the United States will contribute to such nations through segregated accounts which cannot be used for abortion. Moreover, the United States will no longer contribute to separate nongovernmental organisations which perform or actively promote abortion as a method of family planning in other nations. With regard to the United Nations Fund for Population Activities (UNFPA), the United States will insist that no part of its contribution be used for abortion.”³⁰

Thus, the Global Gag Rule prohibits foreign nongovernmental organisations (NGOs) that receive American global health assistance from providing legal abortion services or referrals, while also barring advocacy for abortion law reform even if it is done with the NGO's own, non-US. funds.³¹ The policy allows access to abortion only in cases of rape, incest or when a woman's life is at risk.³² This policy has in effect required foreign non-governmental organisations to certify that they will not “perform or actively promote abortion as a method of family planning,” with non-US. funds as a condition for receiving US global family planning assistance.³³

Since President Reagan enacted the Global Gag Rule – also known as the Mexico City Policy, in 1984, each US President has decided whether to reinstate or revoke the policy by way of an ‘Executive Order’, depending on whether they are a Democratic or Republican president. Notably, it has been implemented by every Republican administration since Ronald Reagan, and rescinded by every Democratic administration.³⁴ Hence, in one of his first actions after he became president, Joe Biden promptly issued an Executive Order rescinding the policy in January 2021. The policy had been reinstated once in 2001 and a second time in 2017, as President George W. Bush and President Donald J. Trump took office, respectively.

In 1984, the original Global Gag Rule applied specifically to the functioning of USAID, but in the version introduced on January 23, 2017, President Trump extended the policy to cover virtually all other US. global health assistance, including US global HIV and maternal and child health assistance.³⁵ In the Presidential Memorandum, President Trump also directed the Secretary of State to take “all necessary actions, to the extent permitted by law, to ensure that US taxpayer dollars do not fund organisations or programmes that support or participate in the management of a programme of coercive abortion or involuntary sterilisation”. The memorandum further directed the implementation of a plan, to the extent allowable by law, to extend the requirements of the reinstated Memorandum to global health assistance furnished by all departments or agencies, notably the Department of State and the Department of Health and Human Services.

On May 9, 2017, the plan, formally called “Protecting Life in Global Health Assistance”, was approved, providing some clarity to President Trump's January 2017 Presidential Memorandum, which was quite vague. The plan provided guidance to the US Government departments and agencies on how to apply the provisions of the Global Gag Rule, stipulating that the policy will apply to all funding agreements (grants, cooperative agreements and contracts) for US global health assistance.

The effect was that the policy applied to a wider range of agencies than initially understood. It applied not only to recipients of family planning funding, but also to recipients of all global health assistance furnished by all US Government departments and agencies. Previously, the President's Emergency Plan for AIDS Relief (PEPFAR) was explicitly excluded in the policy. In the 2017 iteration, PEPFAR and all programmes administered by the Department of State in the President's Cabinet were subject to the Global Gag Rule. Organisations that fund research such as Centers

30. The White House Office of Policy Development, 1984. US Policy Statement for the International Conference on Population. Population and Development Review 10, 574–579. <https://doi.org/10.2307/1973537>

31. Rominski, S., & Greer, S. (2017). The expansion of the global gag rule under the Trump administration.

32. Open Society Foundations (2019). What is the global gag rule? Explainer. <https://www.opensocietyfoundations.org/explainers/what-global-gag-rule>

33. The Mexico City Policy: An Explainer, 2018. Henry J. Kaiser Family Foundation.

34. Rominski, S., & Greer, S. (2017). The expansion of the Global Gag Rule under the Trump Administration.

35. Understanding the Global Gag Rule, 2018. PAI. URL <https://pai.org/understanding-the-policy/> (accessed 11.12.18).

for Disease Control and Prevention (CDC) and National Institutes of Health (NIH) were also subject to the rule. According to the plan, US “global health assistance” includes funding for international health programmes, such as those for HIV/AIDS, maternal and child health, malaria, global health security, family planning and reproductive health, among others.

In March 2019, the Trump Administration expanded the Global Gag Rule further by announcing a new interpretation of language included in the standard provisions implementing the Global Gag Rule.³⁶ Under the new interpretation, a foreign NGO that agreed to comply with the policy either as a direct recipient of US global health assistance or as a sub recipient, was prohibited from providing any financial support to any other foreign NGO involved in activities prohibited under the Global Gag Rule.³⁷ This meant that complying foreign NGOs would no longer use their own, non-US funds to provide financial support for any health or development work of another organisation that does not receive US global health assistance if that organisation separately engages in abortion-related work with its own funding.³⁸ United States NGOs working outside the US with USAID funding were not subject to the Global Gag Rule, but any organisation to which the US NGOs sub-granted USAID funds, were covered by the policy.

However, the expanded Global Gag Rule did not apply to abortions or abortion referrals in cases of rape, incest or to protect the life of the mother, according to the implementation plan. The policy also did not block “passive referrals,” or the provision of information to a woman in response to direct questions if that woman is determined to have an abortion.

These measures expanded the scope of the Global Gag Rule from \$575 million in funding to a whopping US\$12 billion in US global health assistance in 2018.³⁹ While the US Government remains the biggest single funder of family planning programs worldwide,⁴⁰ this expansion covered work unrelated to family planning, including HIV/AIDS, nutrition, malaria, water and sanitation, tuberculosis and other infectious diseases.⁴¹ Over two-thirds of this planned funding – covering 1,309 global health awards in 72 countries for projects spanning HIV/AIDS, maternal and child health, family planning and reproductive health, TB and nutrition – were for awards in Africa.^{42 43}

2. UGANDA’S LEGAL AND POLICY FRAMEWORK ON ABORTION

2.1 The legal framework on abortion

Uganda’s abortion law is a combination of what can be elicited from the country’s Constitution, statutory laws, common law and international human rights instruments. The Uganda Constitution, the country’s supreme law, gives legitimacy to legislative instruments and common law that regulate abortion but falls short of providing for it as a discrete right. It also falls short of substantively enumerating the circumstances under which abortion is authorised.

36. PAI (2019). Absolutely Deplorable: Trump Administration’s Global Gag Rule Interpretation Represents Massive Overreach. <https://pai.org/resources/absolutely-deplorable-trump-administrations-ggr-interpretation-represents-massive-overreach/>

37. PAI (2019). Do You Really Know the Global Gag Rule? <https://pai.org/wp-content/uploads/2019/09/GGR-FAQ.pdf>

38. PAI (2019). Absolutely Deplorable: Trump Administration’s Global Gag Rule Interpretation Represents Massive Overreach. <https://pai.org/resources/absolutely-deplorable-trump-administrations-ggr-interpretation-represents-massive-overreach/>

39. U.S. Government Accountability Office (GAO), (2020). Global Health Assistance: Awardees’ Declinations of US Planned Funding due to Abortion-Related Restrictions. Washington, DC: GAO, 2020, GAO-20-347 <https://www.gao.gov/assets/710/705388.pdf>

40. MSI. Global Impact Report 2019. <https://www.msichoices.org/media/3814/global-impact-report-2019.pdf>

41. PAI (2019). Do You Really Know the Global Gag Rule? <https://pai.org/wp-content/uploads/2019/09/GGR-FAQ.pdf>

42. PAI (2019). Absolutely Deplorable: Trump Administration’s Global Gag Rule Interpretation Represents Massive Overreach. <https://pai.org/resources/absolutely-deplorable-trump-administrations-ggr-interpretation-represents-massive-overreach/>

43. Zara Ahmed (2020). The Unprecedented Expansion of the Global Gag Rule. Guttmacher Policy Review, Vol.23. Guttmacher Institute. <https://www.guttmacher.org/gpr/2020/04/unprecedented-expansion-global-gag-rule-trampling-rights-health-and-free-speech>

Article 22(2) of the Constitution states that: “No person has the right to terminate the life of an unborn child except as may be authorised by law”. This provision implicitly guarantees abortion as a composite right, but the circumstances under which it is permitted are not clearly stated. Since the passing of the Constitution in 1995, no substantive legislation has clarified these circumstances, 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 where 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 criminalises abortion.

Section 224 of the Penal Code provides that;

“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”.

In other words, the law specifically protects some abortion providers. The above provision is widely understood to permit termination of pregnancy to safeguard the life and health of the pregnant woman, although the language used to describe what threatens a potential mother’s life is not clear. 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 defence 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 criminalise 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 Penal Code Act (Section 224) 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.⁴⁴

In 2017, the Center for Health, Human Rights and Development (CEHURD) in 2017 sued the Attorney General of Uganda challenging the Government’s failure to enact a law that provides the circumstances under which a termination of pregnancy can be done in conformity with Article 22(2).⁴⁵ This suit was informed by the Constituent Assembly debates held prior to the formulation and enactment of the 1995 Constitution and Uganda’s high mortality rate due to unsafe abortions and cost of post care abortion in Uganda.

This suit, when and if decided in the affirmative, shall effectively compel the Parliament of Uganda to enact a law that prescribes the circumstances under which an abortion can be carried out. Such a law could definitively determine whether the Global Gag Rule’s scope of prohibited abortion is wider or narrower than the law of Uganda. The Global Gag Rule limits discussion of abortion other than in cases of life endangerment or rape and incest, more exceptions than the Ugandan Penal Code, but considerably fewer than the 2012 National Policy Guidelines and Service Standards on Sexual and Reproductive Health and Rights.

44. Center for Reproductive Rights (CRR), 2012: Briefing Paper: A Technical Guide to Understanding the Legal and Policy Framework on Termination of Pregnancy in Uganda

45. Center for Health, Human Rights and Development (CEHURD) v Attorney General (Constitutional Petition No. 10 of 2017), 2017.

In the meantime, references have been made to case law, particularly the 1938 case in which British gynaecologist Aleck William Bourne was acquitted for performing an operation to terminate a pregnancy in a 14-year-old rape victim. At the time, British law only recognised 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 East 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.

2.2 Policy framework on abortion

The policy framework on abortion is relatively more progressive than the legal framework. The Ministry of Health has provided its guidance in the National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights. The 2006 National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights provide that Ugandans are entitled to “comprehensive abortion care services (CAC).”⁴⁶ In 2012, new guidelines were developed but the Ministry of Health stayed their implementation.

The 2006 Policy Guidelines on CAC provide that CAC should be made available to persons with:

- Severe maternal illnesses threatening the health of a pregnant woman e.g., severe cardiac disease, renal disease, severe pre-eclampsia and eclampsia;
- Severe fetal abnormalities which are not compatible with extra-uterine life e.g., molar pregnancy, anencephaly;
- Cancer of the cervix;
- HIV-positive women requesting for (pregnancy) termination; and
- Rape, incest and defilement.

The 2006 Policy Guidelines further outline the level of facility in which termination of a pregnancy may be performed and what cadre of health workers can perform such procedures. They provide that a medically induced abortion⁴⁷ can be performed in a general or referral hospital, or a health centre IV (HC IV) by a midwife, nurse, clinical officer, medical officer, or gynaecologist/surgeon; and that a surgically conducted abortion⁴⁸ can be performed only in a general or referral hospital and must be done by a gynaecologist/surgeon.

In addition, 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 further provides in its 2007 guidelines for Management of Sexual and Gender Based Violence Survivors for access to termination of pregnancy in cases of sexual violence.

It is worth noting that 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.

46. The Guidelines define CAC as “... 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.”

47. ‘Medically conducted’ abortion refers to an abortion obtained with the use of drugs, such as misoprostol.

48. ‘Surgically induced’ abortion means an abortion performed through the use of a manual vacuum aspiration (MVA) or dilation and curettage (D&C) procedure, or any type of surgical intervention.

3. THE GLOBAL GAG RULE AND SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

The detrimental impact of the Global Gag Rule on SRHR in the Global South, including Uganda have been well documented by CEHURD and partners, global reproductive rights organisations and independent researchers. The policy resulted in reduced access to health services, especially for hard-to-reach groups, including rural populations, youth and adolescents as well as LGBT+ individuals; some communities were left short of qualified service providers; and there has been a chilling effect where organisations, out of caution, toned down country-level advocacy for abortion law reform or discontinued even services that are permitted by the Global Gag Rule, such as post-abortion care, contributing to increased mortality and morbidity from unsafe abortion. A poorly conceived response to the Covid-19 pandemic, involving inconsiderate total local downs in 2020 did not help the situation.

As noted, the state of reproductive rights in American foreign policy and global aid depends virtually on the political party in charge of government. And as expected, President Biden rescinded the policy soon after assuming office in January 2021. However, this was a continuation of a trend that spans 60 years, in which the power of the executive branch of the US Government has steadily increased, with the US. president able to engage in foreign aid and conflict without oversight from the legislature. After the Foreign Assistance Act was passed, President John F. Kennedy set up USAID by executive order in 1961, and it has since been administered by the President and currently accounts for more than half of the US Government foreign assistance.⁴⁹ Hence, President Trump did not need Congressional approval to reinstate the Global Gag Rule, just as he did not need it to cut funding to UNFPA.⁵⁰

In order to limit presidential actions and curb the effects of the Global Gag Rule, though, Congressional support is needed. US-based and global reproductive rights organisations such as International Planned Parenthood Federation (IPPF), Center for Reproductive Rights (CRR), Pathfinder, Center for Health and Gender Equity (CHANGE), PAI and others have advocated for the Global Health Empowerment and Rights (HER) Act, a bi-partisan bill introduced in the US Congress on 24th January 2017 that would, if passed into law, permanently repeal the Global Gag Rule and remove discriminatory restrictions on health services.⁵¹ The Executive Director of CEHURD submitted a testimony to the US House of Representatives Foreign Affairs Committee in support of the Global HER Act on 5th February 2020.⁵²

The CEHURD Executive Director's testimony read, in part:

“As a result of the Global Gag Rule, my organisation has lost key advocacy subgrants. For instance, we had to close down our work halfway into a four-year USAID-funded project on Advocacy for Better Health, despite progress and our good performance on the project. The only reason cited in this project closure was our [refusal] to sign the new addendum (incorporating the Global Gag Rule) when our subgrant was up for renewal. The closure of the project brought an immediate termination of our advocacy interventions that promoted accountability and follow-up on the supply chain of essential medicines in the country... Internally, the closure also meant immediately terminating the contracts of the key project staff, disruptions of the relationships created with project partners, and distorted our coalition's work with partners involved in accountability work for health systems... It is not an easy choice to comply and keep the funding or refuse and lose access to those resources: jobs and indeed lives are on the line. Nevertheless, for CEHURD, this policy is incompatible with our mission and work. Our organisation promotes social justice and human rights to ensure access to health care for vulnerable communities.”⁵³

49 “Who We Are | US Agency for International Development, nd. <https://www.usaid.gov/who-we-are>

50. Nichols, M., 2017. US Withdraws funding for UN Population Fund. Reuters.

51. Global HER Act, 2018. Center for Health and Gender Equity. http://www.genderhealth.org/the_issues/us_foreign_policy/global_her_act/

52. <https://docs.house.gov/meetings/FA/FA00/20200205/110408/HHRG-116-FA00-Wstate-MosesM-20200205.pdf>

53. <https://docs.house.gov/meetings/FA/FA00/20200205/110408/HHRG-116-FA00-Wstate-MosesM-20200205.pdf>

This is just one of the examples of how through the Global Gag Rule, the Trump Administration was able to affect not only the civil society but the vulnerable populations that benefit from their interventions. One of the biggest impacts of the Global Gag Rule on civil society has been in limiting its capacity to challenge and overturn harmful laws. In a restrictive legal environment, advocacy is one of the only tools available to challenge unsafe abortion and support the women and girls who are forced to resort to unsafe abortions. In particular, organisations that work on issues of health will be unable to voice evidence of the deep toll of unsafe abortion in Uganda. Organisations that previously had focused only on service delivery, without investing in advocacy or public engagement, are finding referral networks dismantled and coalitions harmed, rendering service delivery more difficult and advocacy more crucial, even as advocacy is stifled.⁵⁴

Uganda's Constitution guarantees its people the right to freedom of speech and expression, and the large-scale silencing of reproductive rights groups – advocates for liberalisation of abortion or safe abortion – constitutes a threat to this freedom of expression. The Global Gag Rule limits a section of Ugandan civil society that aims to communicate the state of unsafe abortion and the severe harms associated with it, limiting the dissemination of high-quality research and ultimately damaging the state of health and democracy in Uganda. For each rights violation that the Global Gag Rule inflicts on Ugandan people, the silence of the Ugandan government is a telling indicator of low commitment to the SRHR of women and girls.

Another key aspect of the Global Gag Rule is that it violated national level laws, both in the US and in countries that receive aid from the US, especially on freedom of expression and equality before the law. This policy directly places restrictions on healthcare workers in recipient countries – restrictions that do not apply to health workers based in the US Organisations outside of the US --that comply with the Global Gag Rule, as they cannot spend their own funds to undertake advocacy for more conducive legal and policy environments in ways that they deem important to rights of women, which is a blatant infringement of women's rights.⁵⁵ The Global Gag Rule also infringes upon the democratic rights of these NGOs, to participate in the political process. And yet, lawsuits filed within the US, including the three filed in the early 21st century in response to George W. Bush's Global Gag Rule, have failed, largely because US courts find that the US government has no obligations to the rights of non-American women and girls.⁵⁶ And yet, the Government of Uganda, which does have obligations to Ugandan women, girls, and marginalised groups, has not responded to these clear rights infringements.

Further, international reproductive rights organisations and funders based in the US, who faced the threat of a Domestic Gag Rule through the so-called Hyde Amendment, were given a difficult choice of prioritising US reproductive rights over global reproductive rights, endangering mostly the rights of women living in the Global South. Organisations such as the Planned Parenthood Federation of America, Center for Reproductive Rights, and a number of American foundations with programmes in women's health and reproductive rights faced this pressure while also dealing with the impact of the Global Gag Rule in their own advocacy, supply chains, and in the operations of their partner organisations, including non-profit partners in Uganda.

The Global Gag Rule has undermined Uganda's efforts to improve access to family planning and reproductive health, as per the government commitments in policy documents, including the Uganda Coasted Implementation Plan for Family Planning, the National Family Planning Action Plan, and the Family Planning 2020 Commitments. With the bulk of the SRHR services in Uganda being provided by the NGO sector, the impact of the Global Gag Rule has been disastrous, with organisations that chose not to comply with the Global Gag Rule being forced to close clinics and end services as a result of funding deficits, disproportionately affecting vulnerable groups including youth, people living with HIV/AIDS and rural populations.

54. PAI (2018). Access denied: Uganda – Preliminary Impacts of Trump's Expanded Global Gag Rule. Access-Denied_Uganda_March-2018.pdf.

55. Skuster, P., 2004. Advocacy in Whispers: The Impact of the Unsaid Global Gag Rule Upon Free Speech and Free Association in the Context of Abortion Law Reform in Three East African Countries. Michigan Journal of Gender and Law 11.

56. Crimm, N., 2007. The Global Gag Rule: Undermining National Interests by Doing unto Foreign Women and NGOs What Cannot Be Done at Home. Cornell International Law Journal 40, 587–633.

With the closeout of a US funding, in 2017 Marie Stopes projected that it would have had to cut 27 mobile health teams across the country – a key, integrated service for hard-to-reach populations. Five outreach teams had to shut down, with 12 more at risk. From CEHURD's own research, conducted as a case study in November 2020, the country's single largest provider of family planning alongside other SRHR services, Marie Stopes (renamed MSI Reproductive Choices) narrowed down the range of services it provides to CAC funded from alternative sources, including the British (UKAID) and Norwegian (NORAD) governments, and UNFPA.

Marie Stopes had to prematurely close the voucher project and de-franchise clinics. The voucher project, funded by USAID, was instrumental in reaching many poor women with family planning services. At the time of the research, Marie Stopes Uganda (MSU) had just withdrawn the franchise from three clinics in western Uganda, and it was due to withdraw from a further six clinics. The disengagement was largely affecting clinics that do not provide CAC services. In addition, some clinics voluntarily withdrew from the BlueStar network, as the end of payments to clinics has greatly diminished its value. Even for clinics that remained in the network, compliance with MSU's prescribed standards had become a challenge due to limited resources.

"I have de-franchised a facility in Ntungamo, another in Kabale and another in Rukungiri. The reason is that these facilities were not pro-choice. The decision to de-franchise them mainly came when we were defunded for family planning. The little funding which we had was for abortion care and so we had to let clinics that were not pro-choice go." – MSU social franchise regional coordinator, southwest

"Mayanja Memorial Hospital and Ishaka Adventist Hospital were part of my network but they asked to withdraw. Their rationale was that we were no longer paying them for providing the service, and they even no longer get commodities from us but from JMS, so our value to them has diminished. People do not look at the knowledge and skills (provided during support supervision); they look at the money. There are few people who still value the support." – MSU social franchise regional coordinator, southwest

"They (facilities that have withdrawn) are many. In districts like Kampala, we have about four facilities that have pulled out because of no support... Because of the limited funding, these facilities could not pay the providers who were giving out the methods. When funding ended, most of the providers left." –MSU social franchise coordinator, central region.

"Well, we noticed that it has been hard for facilities. It was hard for not just women who were seeking family planning services but also for facilities that were providing the services. If the money that a facility is receiving from its clients is the main source of funding and then people are not coming, then it becomes even harder for us to move there and tell the in-charge to upgrade their premises because we know they don't have money. We have seen some facilities lay off some of their staff; now we have facilities with one or two staff plus the in-charge." – MSU social franchise regional coordinator, southwest

The provision of services through outreaches was scaled down while outreaches through BlueStar clinics virtually stopped. St Augustine Medical Centre in Mbarara in western Uganda used to conduct three community outreaches at private health facilities and lower government health centers (Health Centre II's), per month, with a high turnout. While outreach services were provided free of charge as per Marie Stopes policy – and government policy if conducted at government health facilities – St Augustine clinic had secured a sponsor for vouchers for women that would then be redeemed by Marie Stopes. These outreaches stopped as the Global Gag Rule began to bite.

After the end of the voucher project, Marie Stopes advised the BlueStar clinics to charge the poor and vulnerable mothers for the services they provide. While the clinics continue to receive free commodities through Joint Medical Store (JMS) under the new "One facility one warehouse" programme, clinics normally charge their clients for the service. The challenge, however, is that prices are not regulated and Marie Stopes' appeals to service providers not to overcharge their clients appears to have fallen on deaf ears. Pikwo Medical Centre has resorted to cross-subsidisation – call it price discrimination – where clients who are apparently able to pay are charged a double amount

in order to compensate for those that are either unwilling or unable to pay.

While there is no evidence of a direct link, limited access to outreach during the Global Gag Rule and Covid-19 may have contributed to lower access to contraceptive services, which may have contributed to higher numbers of unplanned pregnancies and higher demand for CAC services. When Covid-19 broke out and a lockdown was imposed, it became even more difficult for women to access family planning. Service providers report that there has been an increase in the number of women seeking abortion and post-abortion care services.

Clinics participating in this study report that they received many calls from women seeking help but in many cases the clinic was unhelpful, as it was unviable to provide door-door delivery. The clinic received calls from desperate women seeking help with unplanned pregnancies, likely conceived after failing to access contraceptives. With Covid-19, the demand for services nosedived, and so did the clinic's income.

“The complaint from our partners is that people come demanding for the service and yet they have no money to pay. So, many of them go back without the service and end up with unplanned pregnancies and needing abortion services.” – social franchise coordinator, central region

“People were not coming as before simply because they were told not to move. Secondly, economically people did not have money. In terms of demand, it rose because I could receive phone calls made by people demanding for services. I have about five beds here and they are for abortion care services but there was no way they could reach here. It reached a time when I hired a van that acted as an ambulance to reach out to those people who needed the service but the cost was prohibitive,” – manager, Marie Stopes Gulu.

“Unfortunately, right now women have to pay the cost for each of these which are so expensive. After the GGR, different facilities charge different prices. We usually encourage facilities not to exceed certain prices for different methods. For instance, under the facilities I oversee, I recommend that an implant should not exceed UGX 10,000. We try to control the pricing but that is difficult because if you dictate low amounts for these commodities, then facilities won't be able to cater for their own expenses and operational costs.” – MSU social franchise coordinator, southwest region

With reduced activity and funds, MSU and BlueStar clinics had to reduce their staff. For example, at the Gulu clinic, MSU reduced its staff from 14 to seven, and the remaining ones had to do with half pay in salaries and allowances. While the number of outreach teams operated by MSU largely remained the same, they became thinner and less active. Some staff were laid off because their work was funded by USAID. There were effects on retention and remuneration of staff which affected the operations of MSU clinics. For example, Bazadde Medical Centre in Kampala suspended salaries to its staff. The clinic also began to experience commodity stock-outs.

“What has changed is that we have reduced the manpower that used to conduct these outreaches. For example, you see me driving that Landcruiser but before that I had a driver. The driver was taken away and now I have to drive myself.” – social franchise regional coordinator, southwest region.

“Of course, when we lost the funding, we lost staff because they could not pay them. Some became redundant because the work they were doing was no longer being funded. Others with contracts were terminated. Even the facilities themselves, some were kicked out because of funding. That is why we have other facilities that are now supporting themselves.” – Social franchise coordinator, central region

“Of course, the clients did not take it well, but we did not have anywhere to get the resources so we had to make them pay. But of course, they also disappeared, every person who came and you told them an implant is UGX 20,000, they would tell you, ‘let me come back’ and you won't see them again... And it reached a time and some methods also disappeared. The injection, one of the most used methods,

disappeared. Sometimes, the pills also disappeared, so people were just there.” – Director, St Augustine Medical Centre

Even the staff that were able to retain their jobs and proprietors that kept their clinics operational lost the motivation and morale waned among clinic proprietors, frontline service providers and clients. Marie Stopes as an organisation suffered a reputational blow and reports that they have received numerous inquiries about “when all this will end”.

“Of course, some people had to go because you know when you have high numbers of people seeking services you need more hands. So, (when demand fell) I had to let off some people, indefinitely. I even closed one of the branches – the Isingiro one – and sold the one in Ntungamo. I gave it to one of my staff members, the money that was coming in was too little for me to keep going there every now and then.” – Director, St Augustine Medical Centre

4. CONCLUSIONS AND RECOMMENDATIONS

The Global Gag Rule and its impact are a clear demonstration of the link between politics, the law and health outcomes and it is undeniable that throughout history, political decisions have played a critical role in shaping the development of reproductive rights approaches and indicators for women. Fundamentalism seems to have a continued dominance over women, girls and mothers, especially when it comes to their ability to decide when, if, and how many children to have. We need to operationalise the human rights-based approaches – evidence-based policies and global solidarity should not be ignored as a key factor in health systems strengthening. Maternal and reproductive health should not be a privilege for some, but a right for all.

Family planning was an entry point for many women who needed to procure an abortion, because they took the opportunity of outreach camps to approach service providers for guidance and help. When service providers mobilised women for family planning outreaches, women who wanted CAC would come among those seeking family planning. When the outreaches ended, women seeking CAC lost the opportunity as well due to the stigma traditionally associated with procurement of an abortion. The restrictive legal environment has not been supportive of CAC service providers, and the law has been applied expansively to harass even PAC providers. The Global Gag Rule has played a role in perpetuating abortion-related stigma and to buttress conservative voices.

In many ways, the Global Gag Rule is an immutably difficult policy to dislodge. But there is an opportunity with the Global HER Bill, which the human rights community must seize. The Global Gag Rule was put in place by President Trump, in its expanded form, with essentially no review or democratic process. The United States has no legal obligations to the women and girls affected by this disastrous policy, but it has a moral obligation. Unfortunately, for much of Trump’s administration, the Global Gag Rule was implemented with minimal clarity and accountability to the organisations it affected. And the Ugandan government had no explicit response. But the fact remains that the Global Gag Rule affected the human right to health of women in Uganda and around the world, and that now there is crucial work to do in mitigating its effects.

There are short term and long-term ways for civil society. Short term, funders must act to close gaps in programs and advocacy, and strategically replace funding lost to the Global Gag Rule. NGOs must act to share information and strategies, and map where funding shifted. Advocates should push the Ugandan government and US global health bodies within Uganda alike for dialogue, and condemnation of the Global Gag Rule and a quick return to

normalcy. In the longer term, much depends on the domestic politics of the United States, specifically in passing the Global HER Act through Congress to end the drama of the Global Gag Rule, but to the activist community to build a movement to support the reproductive rights of women.

The Global Gag Rule is a wake-up call for Uganda: it not only has the capacity of dwindling Uganda's efforts in making successes in the area of SRHR, it also curtails Uganda's capacity to address the issue of maternal mortality due to unsafe abortions and general health and wellbeing of its citizens. In addition, Uganda has a choice to make, to either remain dependent to US foreign aid and compliant with the intermittent Global Gag Rule, or to work towards self-determination and fulfillment of the right to health.

Advocacy should focus on avoiding a return to the Global Gag Rule, even when there is a return to a Republican administration in the United States. The civil society should sensitise partners about the policy and build a movement against a future return of the policy by supporting the enactment of the Global HER Act.

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