



**CEHURD**  
social justice in health

A background image showing several hands of different skin tones overlapping and resting on each other, symbolizing support and care. The image is overlaid with a dark red gradient.

**REFERENCE GUIDE ON LEGAL  
CONSIDERATIONS FOR CLINICAL  
DECISION MAKING WHEN PREGNANCY  
PLACES A WOMAN'S LIFE AT RISK**

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**Reference Guide for Health Practitioners**

**MARCH 2022**

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**Disclaimer:** This document should not be construed as medical or legal advice but the recommendations made are drawn from international best practices.international best practices.

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## LIST OF ACRONYMS

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<b>AOGU</b>	Association of Gynecologists and Obstetricians in Uganda
<b>CEHURD</b>	Center for Health, Human Rights and Development
<b>CSE</b>	Comprehensive Sexuality Education
<b>CSOs</b>	Civil Society Organizations
<b>HRM</b>	Harm Reduction Model
<b>RHU</b>	Reproductive Health Uganda
<b>SRHR</b>	Sexual and Reproductive Health and Rights
<b>UDHS</b>	Uganda Demographic and Health Survey

# 1. BACKGROUND TO THE CLINICAL GUIDELINES

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In 2018 Fòs Feminista, Women's Link Worldwide and Iniciativas Sanitarias developed guidelines for clinical decision making when pregnancy places the woman's life at risk, with a focus on the Latin American and Caribbean setting. According to the guidelines, most countries in the Latin American and Caribbean settings have criminal laws against voluntary abortion and regulate access to it, with exceptions for certain circumstances. These are referred to as "exceptions, grounds or indications" and are briefly summarized as below:

- The life exception: when the pregnancy places the woman's life at risk
- The health exception: when the pregnancy endangers the woman's health
- The rape exception: when the pregnancy is the result of non-consensual sexual contact.
- In some contexts, fetal malformations and socioeconomic hardship are regarded as exceptions.

However, despite these exceptions, it is often difficult for people to legally access termination of pregnancy services. This is partly due to the lack of knowledge about these grounds and the requirements therein, creating indecision and confusion among health workers on which circumstances allow them to legally perform abortions. Indeed, health workers often find it difficult to determine whether there is a risk to the woman's life resulting from pregnancy and whether they should offer legal termination as one of the treatment options.

These clinical decision-making guidelines focus on the right to life exception because it has not been well understood or analyzed, unlike the health and rape exceptions on which progress has been made over the years. This is partly because assessing the right to life is a complex process that does not simply involve identifying the presence or absence of vital signs of life, or clear cases like hemorrhaging placenta previa, but goes beyond these to understand psychosocial health and other influencing factors. Indeed, a comprehensive assessment is required, which is affected by many complexities, especially

where there is already stigma and discrimination against women.

The model requires a concurrent use of both medical and legal approaches, with an understanding of bioethics and international human rights laws. The intention is that these guidelines provide a way in which health workers can quickly but thoroughly judge that the life of the pregnant girl or woman is at risk and why, while simultaneously working within the confines of the law, observing the woman's human rights as well as the bioethical principles to which health workers are bound. It is intended to increase certainty of health workers while they make decisions on termination of pregnancy.

Furthermore, risk to life from pregnancy requires health workers to consider a broad range of available solutions, not only termination. However, the final choice must be made by the pregnant woman or girl, with context specific laws applying in cases where she is unconscious, a minor, or of decreased mental ability at the time when the decision is needed.

## 2. | **CONTEXT OF SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN UGANDA**

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Uganda has a high fertility rate of about 4.8 children per woman.<sup>1</sup> There is also a high percentage of teenage pregnancies - it is reported that among girls aged 15-19 years, 25% of them had already begun childbearing, with the figure higher in rural areas, amongst those with lower education and those in lower wealth quintiles.<sup>2</sup> In Uganda, abortion is restricted by law. Furthermore, it is associated with a lot of stigma, including from religious leaders,<sup>3</sup> other moral issues and social proscriptions and situations of ambivalence. A discourse analysis of induced abortions in Uganda's daily newspapers found that most representation in the media took either a religious discourse that views abortion as murder, evil and forbidden in the Bible and as blaming young women, or a human rights discourse with debate on the woman's right to life and health and

1. <https://data.worldbank.org/indicator/SP.DYN.TFRT.IN?locations=UG> last visited on 12th May 2021

2. Supra

3. J.B Babigumira et al, Estimating the costs of induced abortion in Uganda: A model-based analysis, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3293098/> last visited on 10th June 2021

the unborn babies right to life, all supported by legal and medical discourses.<sup>4</sup> All these constitute multiple barriers to safe and legal abortion in the country.

Despite the restrictions, a high number of abortions are conducted annually in Uganda. In 2013, approximately 314,304 abortions were conducted, with an estimated 128,682 women receiving treatment for complications related to abortion.<sup>5</sup> The same study reports variations in abortion rates per region, getting to as high as 77 per 1,000 women aged 15–49 in Kampala, compared to 39 abortions per 1,000 women nationally. Additionally, a study estimating the incidence of abortion among adolescents in Uganda reported an estimate of 57,000 abortions among adolescents and amongst the sexually active women, adolescents had the highest abortion rate of 76.1 abortions per 1000 women aged 15–19 years.<sup>6</sup> However, the study focused on only those women who came to health facilities with complications.

These figures on abortion are likely to be an underestimate because few studies have been done on abortion in the country. Most studies have had a smaller geographical or demographic scope, rather than regional or countrywide, or are done among women who come to health facilities, missing out on those in the community. Additionally, many abortions are conducted clandestinely and are not known about or reported unless the woman requires post abortion care or dies, and the death is registered accurately. Therefore, the true figures on induced abortions are probably higher.

Many of the induced abortions done are unsafe, provided by untrained people, or using inappropriate methods, sometimes done by the woman herself. Therefore, they result in multiple complications that are subsequently responsible for a high proportion of maternal mortality in the country.<sup>7</sup> Indeed, although Uganda's maternal mortality ratio has reduced over the years, it remains high at 336 deaths per 100,000 births, with unsafe abortions contributing over 8% to these figures.<sup>8</sup> Other outcomes include perforation, sepsis, severe vaginal bleeding,

4. Larsson S, Eliasson M, Allvin MK et al. 2015. The discourses on induced abortion in Ugandan daily newspapers: a discourse analysis. *Reproductive Health* 12.

5 Prada E, Atuyambe LM, Blades NM, Bukenya 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> last visited on 10th June 2021.

6. Ibid

7. Kagaha A, Manderson L. 2020. Medical technologies and abortion care in Eastern Uganda. *Social Science & Medicine* 247: 112813.

8. Uganda Demographic Health Survey, 2016

uterine rupture and others.<sup>9</sup>

Equally, abortions and treatment of associated complications result in a high use of resources that could have been better used elsewhere. A study done to estimate the costs of induced abortion in Uganda in 2011 reported that on average, patients spent \$62 dollars, while governments spent \$14, with a projected national annual expenditure of costs to patients at \$22.3 million; \$5.1 million costs to government and \$23.6 million on direct medical costs.<sup>10</sup>

CEHURD leveraged on its expertise in using the Harm Reduction Model (HRM) and working with relevant partners including Ministry officials, CSOs, the legal fraternity, health service providers and women to analyze the guidelines for clinical decision-making when pregnancy places the woman's life at risk and made the following recommendations;

- There is a clear nexus between pregnancy and mental health which remains largely ignored. Abortion is at times recommended on psychological grounds but there is a gap between mental health practitioners and reproductive health practitioners to aid access. Therefore mental health and reproductive health practitioners should be oriented on how to make an assessment of when pregnancy places a woman's life at risk to allow for a safe and legal abortion.
- The breadth of assessment required by the Latin American guidelines requires knowledge of the law and therefore health workers should be oriented on making such an assessment right from medical school.
- Social risks should be noted (where they exist) when they exacerbate or accompany biological and psychological risks to build evidence to support the social risk standing alone.

.....  
9. Ibid. Note 15

10. <https://www.gutmacher.org/fact-sheet/abortion-and-postabortion-care-uganda> last visited on 10th June 2021

### 3. LEGAL AND POLICY PROVISIONS ON ABORTION

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- **The Constitution of the Republic of Uganda, 1995**

The Parliament of Uganda has not yet passed an express law that governs the circumstances under which an abortion can be procured since the passing of the Constitution in 1995. The provision of abortion in Uganda is highly restricted. The 1995 Constitution of the Republic of Uganda as amended is the supreme law of Uganda from which all other laws derive their mandate, Article 22 prohibits the deprivation of the life of any person including a fetus, except as authorized by law.

- **The Penal Code Act, cap 120**

The Penal Code Act Section 224 has provisions which criminalize induced abortion by creating offences on procuring an abortion, taking drugs to induce an abortion and the sale and supply of drugs (including abortifacients) to induce an abortion. While the Penal Code largely criminalizes abortion, it provides a defense strictly for those providing and the person who gets the abortion charged under these offences in Section 224 as below; “Where a person who in good faith and with reasonable care and skill performs a surgical operation upon an unborn child for the purpose of saving the mother’s life”

The basis for this defense is contained in R vs. Bourne [1939] 1 K. B. 687, where a 14-year-old girl was raped by five soldiers and became pregnant as a result. An eminent gynecologist performed an abortion on her and was charged with the offence of conducting an illegal abortion. He was acquitted and Hon Macnaghten J said, “If the doctor is of the opinion, on reasonable grounds and with adequate knowledge, that the probable consequence of the continuance of the pregnancy will be to make the woman a physical or mental wreck, the jury are entitled to take the view that the doctor is operating for the purpose of preserving the life of the mother.”

- **The National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights 2006**

These provide guidance for the management and prevention of unsafe abortion and highlight several considerations for when a person can access comprehensive abortion care. The grounds set down to perform an abortion are as below:

- a) Severe maternal illnesses threatening the health of pregnant woman
- b) Severe fetal abnormalities
- c) Cervical cancer
- d) HIV-positive women requesting
- e) Victims of rape, incest, and defilement

It is also important to note that provision of post abortion care in Uganda is permitted. According to the 2006 guidelines, post abortion care is an integral part of sexual and reproductive health services and is to be provided on a 24-hour basis, in all hospitals and health centers where there are doctors, midwives and clinical officers trained in comprehensive abortion care and where the minimum hygienic standards are met.

## **4. HOW TO APPLY THE CLINICAL GUIDELINES**

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The Latin America clinical guidelines for decision making when pregnancy places the woman's life at risk provide healthcare personnel with the tools for decision making when faced with the hard choice of providing a safe and legal abortion in a restrictive environment which only allows an abortion where the woman's life is at risk.

The guidelines provide a global medical standard, clarity and detail the circumstances that place a woman's life at risk beyond the traditional danger of imminent death or the presence or absence of signs of physical death. The guidelines emphasize that:

- The risk must be specific and individualized. In other words, it must be precise, definite, and unambiguous.
- It must be real, meaning that there must be objective elements that allow an inference that there is a reasonable likelihood or possibility of harm. It cannot be a potential or remote danger.
- In terms of timing, the risk may be immediate, imminent, or future.
- Risk to life has an intrinsic component, based on specific characteristics of the pregnant woman or girl, such as a predisposition to contracting a particular disease.
- It also has an external component related to the measures taken by the care team and the structure and capacities of the healthcare system.

The guidelines recommend that health workers while taking a risk analysis instead of looking at things in isolation should use a holistic approach while assessing pregnancy i.e., the social, biological, and psychological variables and form a broader construction of what places a woman's life at risk. This can be done through identification of risk factors and the dimension of life that is placed at risk.

In assessing the biological, psychological, and social risks we need to keep in mind that women of reproductive age refer to all women aged 15–49 years which includes adolescents. Unfortunately, the age of majority is generally recognized in national and international law to be 18 years, and from the reading of the law, capacity to consent to medical treatment is a preserve of adults.

For minors to access safe abortion services, written consent should be obtained from the parent or legal guardian especially for evacuation for incomplete abortion, examination under general anesthesia and any surgical interventions.

### **a. Considering the biological risk**

The clinical guidelines for decision making when pregnancy places the woman's life at risk refer to biological risk factors as one way of assessing pregnancy related risk to life.

#### **Considerations for biological risk in Uganda**

- a. Severe maternal illnesses threatening the health of a pregnant woman e.g severe cardiac disease, renal disease, severe pre-eclampsia and eclampsia
- b. Severe foetal abnormalities which are not compatible with extra-uterine life e.g molar pregnancy, anencephaly
- c. Cervical cancer

#### **Considerations for biological under Latin American guidelines**

- A woman develops a condition during pregnancy that causes health complications e.g. hypertension but no pre-existing illness.
- A woman has pre-existing illness that is worsened by pregnancy e.g heart disease.
- A woman has a pre-existing illness whose treatment is limited by pregnancy or pregnancy is a contra-indication e.g cancer

### **b. Considering the psychological risk**

According to the Clinical Guidelines, psychological risk factors (factors that affect or arise in the mind and are related to the mental and emotional state of a person) were identified as being one of the considerations that could place a woman's life at risk resulting from a pregnancy.

### Considerations for psychological risk in Uganda

- Having regard to the patient's state at the time
- Having regard to all the circumstances of the case
- Rapo, incest and defilement

#### c. Considering the social risk

The clinical guidelines for decision making when pregnancy places the woman's life at risk refer to social risk factors as one way of assessing pregnancy related risk to life.

Considerations include: -

### Considerations for social risk in Uganda

- Having regard to the patient's state at the time.
- Having regard to all the circumstances of the case

### Considerations for psychological risk under Latin American guidelines

- Pre-existing mental illness that worsens, or may worsen with pregnancy
- No pre-existing mental illness but risk for adverse mental health events in the future e.g due to vulnerability; or social or personal factors about the origin of the pregnancy
- Mental illness caused by poor development or prognosis of the pregnancy e.g fetal malformation
- Pregnant in a context that threatens her dignity or quality of life e.g forced to keep an unwanted pregnancy

### Considerations for psychological risk under Latin American guidelines

- Poverty related malnutrition
- Bas working conditions e.g in mines
- Traditional practices that increase violence and discrimination against women e.g pregnancy outside marriage.
- Gender inequalities
- Poverty / wealth inequalities
- Lack of access to quality health care services (diligence)

# EXAMPLES OF CASE STUDIES ON HOW TO MAKE THE ASSESSMENT

## Case 1: Pulmonary Hypertension

*“A 27-year-old woman presents to the emergency department complaining of difficulty breathing for two days that has worsened in the last three hours. She reports asthenia, adynamia, and edema in the legs, particularly in the evening, for the last two weeks”.*

### History

#### **No significant family history.**

Patient history of congenital heart disease detected at age two, uncorrected. Menarche at age 13. No previous pregnancies. Irregular cycles at 60-90 days, lasting three to four days. Uses condoms. Last menstrual period: three months ago.

### Physical examination

Examination shows a patient who is conscious, hydrated, and afebrile. Blood pressure 110/70 mmHg, oral temperature 36.2, heart rate 80 beats per minute, respiratory rate 30 per minute. Hyperactive precordium, thrill at the second intercostal space (ICS). Auscultation shows cardiac arrhythmia, harsh V/VI holosystolic murmur radiating to the apex, extending to the seventh ICS at the mid-axillary line; abdomen soft and non-tender, bowel sounds present; 0.5 cm hepatomegaly detected with difficulty below the costal margin. Speculoscopy shows vagina with violaceous walls and closed posterior cervix. Manual examination shows vagina with elastic walls, soft, closed, posterior cervix; enlarged uterus palpated in anteversion and anteflexion. Chest X-ray shows global cardiomegaly, prominent pulmonary artery, significant venocapillary congestion, cottony image suggesting acute pulmonary edema. Echocardiogram: 20 mm atrial septal defect, pulmonary valve stenosis.

ECG: atrioventricular dissociation, third-degree atrioventricular block, with ventricular escape rhythm and bigeminy.

Pregnancy test: positive.

Obstetric sonogram: nine weeks pregnant

## Diagnosis

Patient diagnosed nine weeks pregnant by ultrasonography, with congenital acyanotic heart disease with increased pulmonary flow.

- Large interatrial communication and pulmonary stenosis.
- Tricuspid insufficiency.
- Congestive heart failure.
- Severe pulmonary hypertension.
- Complete atrioventricular block.
- Biatrial enlargement.

## Intervention

The risk is explained to the patient, and she decides to terminate the pregnancy. The patient is also informed of the risks associated with future pregnancies and the importance of immediate post-abortion contraception. Loop diuretic, prophylaxis for bacterial endocarditis, and thromboprophylaxis are prescribed. Central catheter placed in intensive care. Cardiology suggests placing a permanent pacemaker, closing the interatrial communication, and surgery for pulmonary stenosis, after the pregnancy is terminated.

Treatment is initiated with spironolactone and low-dose ACE inhibitors. Termination of pregnancy is performed. Four days later, when the patient is discharged from intensive care, she is hemodynamically stable. She remains hospitalized for four more days while the Cardiac Surgery Service prepares her for surgery.

## Risk

Pulmonary hypertension causes maternal death in 30% to 50% of women affected; contraceptive counseling should therefore emphasize the risks associated with pregnancy and patients should be advised against becoming pregnant. Hemodynamic changes associated with pregnancy, childbirth, and the postpartum period may place a pregnant woman with pulmonary hypertension at risk. There are three times of particular risk of decompensation as a result of a sudden increase or decrease in volume that a failing ventricle must handle. The first is in the late second trimester (28 to 32 weeks), which is the period of greatest expansion of plasma volume. The second is during uterine contractions in labor, which produce blood flow from the uteroplacental circulation to the vena cava, with a consequent increase in cardiac output of between 15% and 20%. Moreover, the mother's pushing during the second stage of labor, through a mechanical compressive process, causes a decrease in venous return that may become critical. Finally, the third critical period is early postpartum, because after birth, when uterine retraction has begun, the mechanical obstruction of the vena cava is removed, with a corresponding increase in venous return, leading to an increase in systemic vascular resistance and rapid blood flow from the uteroplacental circulation. All of these changes must be handled by the heart.

Some studies have found that this is the cardiovascular condition that causes the most cases of maternal mortality. Most maternal deaths occur between the seventh and ninth day of the postpartum period. Taking into account gestational age, viability of the fetus, clinical deterioration, and the patient's wishes, a pregnant woman with pulmonary hypertension should be offered the opportunity to have a legal abortion for medical reasons. The procedure should be performed as early as possible. Maternal mortality rates associated with voluntary termination of pregnancy have not been determined, but they do increase the later the procedure is performed; nonetheless, they are always lower than mortality rates associated with pregnancy.

As noted above, a woman with pulmonary hypertension should not become pregnant, and once the abortion is performed, she should use her choice of effective contraceptive, such as vasectomy or female sterilization immediately post-abortion. If the patient is firmly opposed to sterilization, the alternative would be to use a reversible, long-lasting method such as contraceptive implants or an IUD.

## Legal and ethical basis

- There is specific and individualizable danger: The patient is a 27-year-old pregnant woman with severe pulmonary hypertension.
- There is real danger: Pregnancy is contraindicated in women with pulmonary hypertension, which is known to be aggravated by pregnancy and childbirth. The further along the pregnancy, the greater the risk to the woman. In addition, the patient in this case presents with severe pulmonary hypertension.
- The risk of harm concerns a valuable and irreplaceable interest: Continuing with the pregnancy entails the risk of death. In other words, the legal interest in danger is the woman's life.
- The risk is exceptional: Losing one's life because of the impact of pregnancy on pulmonary hypertension is not a general risk; that is, it is not the sort of risk that can and should be taken on by any person receiving medical treatment, such as the risks accepted when receiving anesthesia. Pulmonary hypertension is a severe health condition that requires a treatment protocol adapted to the patient's specific circumstances and designed to preserve her life, dignity, and quality of life.

In this example, continuing with the pregnancy would only exacerbate the patient's pulmonary hypertension, and her chances of carrying the pregnancy to term are nil. Therefore, the course of treatment to avoid risk of harm is legal termination of pregnancy.

Voluntary termination of pregnancy is legal under all national and international laws protecting the rights to life and health and patients' rights.

## Application in the Uganda context

## National standards applicable to the specific case:

- Constitution of the Republic of Uganda: Constitutional objectives XIV(b) (Right to health) and XX (Medical services); article 8(A); article 20 (Fundamental and other human rights and freedoms); article 21(1) (Equality and freedom from discrimination); article 22 (Right to life); article 24 (Human dignity); article 33 (Full and equal dignity of women); article 33(2) (Affirmative action in favour of marginalised group); article 41 (Right to information); article 44(a) (Prohibition of derogation from particular human rights and freedoms – freedom from torture and cruel, inhuman or degrading treatment or punishment); article 45 (Human rights freedom additional to others rights).
- Penal Code: article 224 (surgical operation). This section provides a clear exception to the criminalization of abortion in cases where the termination of pregnancy is necessary to preserve the woman's life.
- Code of Professional Ethics (Medical and Dental Practitioners): The practitioner shall not violate the patient's human rights (article 4) and not deny emergency treatment or health care to a patient (article 8).
- Patient's Charter: article 1 (right to medical care); article 15 (confidentiality and privacy).
- National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights.
- National Health Policy.
- National Standards and Guidelines for Reducing Maternal Morbidity and Mortality from Unsafe Abortion in Uganda (ATTENTION!! provisionally suspended). Despite having been suspended, the creation of these norms in 2015 indicates a certain recognition by the State that there is a public health problem related to sexual and reproductive rights, especially in the context of unsafe abortions.

## CASE STUDY:

- There is a specific and individualizable risk. This is a 27-year-old pregnant woman with severe pulmonary hypertension.
- Existence of a certain danger: in women, PHT entails a recommendation not to become pregnant, since it is recognized as a disease that is aggravated by pregnancy and childbirth. Moreover, the more advanced the pregnancy, the greater the risk for the woman. In this case, moreover, the woman presents for consultation with severe PHT.
- From a point of view that respects the woman's dignity, and therefore, when we look at the woman as the holder of autonomy of will, of the right to privacy, to sexual freedom, as well as physical, moral, psychological and health integrity, we will have that she is able to decide freely, without any kind of interference from the State, about her body and, thus, opt for the maintenance or interruption, even without relevant reasons, of an unwanted pregnancy. In this specific case, it must be emphasized that we are not even facing an absence of a "relevant reason", but rather a woman who is at risk of losing her life if she continues her pregnancy.
- The risk of harm falls on a valuable and non-substitutable asset: if the pregnancy continues, the risk is death or, in other words, the legal asset at risk is the woman's life. This legal right is protected under article 22 of the Constitution of Uganda. Having a dignified life is about defending one's own existence and to exist with dignity, it involves the right to preserve the physical-psychic and spiritual-moral attributes of the human person. What is at stake are personal decisions, individual ethics and individual values, understanding that each citizen, as an individual person, has the right and the duty to take a position, after honest and understandable information, according to her values.

- The risk is exceptional: losing one's life due to the association between PAH and pregnancy is not a general risk. That is, a risk of the type that should not and can be assumed by anyone receiving medical treatment, since PAH is a severe health condition. PHT is a severe health condition, which requires a treatment protocol adapted to the specific circumstances of the patient and aimed at preserving his or her life in conditions of dignity and quality. These rights are regulated and recognized as a National Objectives Principles of State Policy (XIV, XX) and by articles 21, 22, 24, 32(2), 33 and 41 of the Constitution of Uganda; articles 4, 8, 11, and 34 of the Professional Code of Conduct and Ethics for Medical and Dental Practitioners; articles 1, 2, 15 and 25 of the Patient's Charter; and promoted in the National Health Policy and the National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights; the Judgment of the Constitutional Court Case N° 2 of 1997 (NODPSP can be used in interpreting the Constitution) – human rights treaties can be used as criteria for the interpretation of constitutional rights (ICESCR, CEDAW, The African Charter, Maputo Protocol).
- The Chapter 4.13 of the National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights states that “people who can get services for termination of pregnancy: (i) severe maternal illnesses threatening the health of a pregnant woman e.g. severe cardiac disease, renal disease, severe pre-eclampsia and eclampsia”, among other circumstances. In this sense, this provision should not be interpreted as an exhaustive list, but rather as an illustrative one since the legislator himself chose to use the abbreviation for the Latin phrase “*exempli gratia*” (“for example”). Thus, any serious disease that endangers the life of the woman can be considered a reason for termination of pregnancy – Considering the maternal mortality rate derived from pulmonary hypertension, the patient's right to life must be safeguarded and the abortion performed.

- Considering the circumstances of the case, where continuation of the pregnancy would aggravate the woman's pulmonary hypertension and, that this disease is the cause of 30% to 50% of maternal deaths, the health professional, acting in good faith and with reasonable care and skill, cannot be criminally charged (Article 224 of the Penal Code).
- In addition, according to the National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights a patient has the right to a comprehensive abortion care when a severe maternal illness threatening her health (Chapter 4.13). Besides, it's a patient's right to receive an adequate post-abortion care on a 24-hour basis. The services are to be provided in all hospitals and health centers where there are doctors, midwives and clinical officers trained in comprehensive abortion care and where the minimum hygienic standards are met.

In the example case, continuation of the pregnancy only aggravates the patient's PHT, which makes her chances of being able to continue and carry the pregnancy to term non-existent. Therefore, the course of treatment to avoid the risk of harm is abortion.

The legality of abortion is supported by all national and international legislation protecting the right to life, the right to health and the rights of the patient.

## Case 2: Suicide Attempt

*“The patient is a 16-year-old girl referred for legal abortion. She is 14 weeks pregnant and has a history of a suicide attempt”.*

### History

Patient’s father is 55 years old, a doctor in a remote region, drinks to excess, not receiving treatment for alcoholism. He was diagnosed with prostate cancer last year and is undergoing radiation therapy. The mother died when the patient was eight years old. She found her hanging from a beam, tried unsuccessfully to get the body down, then held on to her legs until other family members arrived, without crying. She was raised by her maternal grandmother, sometimes staying with her father and his new wife, with whom she has a relationship marked by mutual hostility.

The patient was born prematurely at 36 weeks by caesarean section, but developed normally. She began school at six years of age and has not repeated any classes. She went to school until the fourth year of secondary school, then dropped out because of the current pregnancy, which was unplanned and unwanted. Menarche at age 12. Started sexual activity at age 12, without contraception. G1.

At the age of 11, she made a suicide attempt by taking 20 diazepam tablets “to be with her mother.” Her stomach was pumped and she was given flumazenil. A mental health evaluation was not done, by the father’s choice. She got pregnant by a 17-year-old boy. He is very frightened, and the patient’s father has threatened his life if he comes around her. The pregnancy is seen as a very unfortunate development.

### Mental examination

The patient is an adolescent who appears older than her chronological age. She is awake, oriented, hostile, and will not look at the interviewer. In tears, she says that she does not want the pregnancy, and she would rather die than continue. She recounts her mother’s suicide without displaying much emotion. Mystical delusions and delusions of external control. Auditory hallucinations of the voice

of a woman telling her to kill herself to be with her mother. No future plans, no emotional bond with the pregnancy. Anergia, anhedonia, lack of interest in her environment. Lacking capacity for self-analysis. Lacking insight into of condition.

## **Diagnosis**

The patient is admitted with a diagnosis by sonogram of pregnancy with a gestational age of 14 weeks and bipolar disorder, depressive phases, with psychotic symptoms.

## **Intervention**

The option of legal termination of pregnancy is offered, and the patient and her father agree.

## **Risk**

The patient is a young woman who presents the following risk factors:

- Born prematurely.
- Mother's death by suicide when the patient was eight years old.
- Neglect and psychological violence from the father and his new partner.
- History of a suicide attempt at age 11.
- Current signs of depression and psychosis.

Taken together, these factors represent a serious suicide risk, which is known to be common among pregnant adolescents. The death by suicide of a family member is a powerful predictor of suicide.

## **Legal and ethical basis**

- There is specific and individualizable danger: The patient is a 16-year-old pregnant adolescent who has attempted suicide in the past.
- There is real danger: Suicide is a frequent cause of maternal death.

- The risk of harm concerns a valuable and irreplaceable interest: Continuing with the pregnancy would increase risk of suicide and therefore the patient's death. Furthermore, a pregnancy causing this level of distress drastically reduces chances of treatment and recovery for the patient's mental health and may lead to disability, which constitutes a substantial loss of quality of life and dignity.
- The risk is exceptional: Mental health problems with suicide attempts require early intervention to reduce or eliminate risk of death. The risk of killing oneself is not the sort of risk that can and should be taken on by any person. Mental health patients require interventions designed specifically to protect their life. When pregnancy becomes a mental health stressor that may lead to suicidal behavior, the course of treatment to prevent risk of harm is legal termination of pregnancy. Measures designed to immobilize, sedate, or deprive pregnant women or girls at risk for suicide of their liberty until the pregnancy reaches term affect all three components of quality of life and all three dimensions of life with dignity, with very slim likelihood of therapeutic success for the patient. Furthermore, such practices constitute forms of torture and are illegal. Therefore, the course of treatment to prevent risk of harm is legal termination of pregnancy.

Voluntary termination of pregnancy is legal under all national and international laws protecting the rights to life and health and patients' rights.

### **Application in the Uganda context**

- National standards applicable to the specific case:
- Constitution of the Republic of Uganda: Constitutional objectives XIV(b) (Right to health) and XX (Medical services); article 8(A); article 17(c) (Duties of citizen); article 20 (Fundamental and other human rights and freedoms); article 21(1) (Equality and freedom from discrimination); article 22 (Right to life); article 24 (Human dignity); article 33 (Full and equal dignity of women); article 33(2)

(Affirmative action in favour of marginalised group); article 41 (Right to information); article 34 (Rights of Children); article 44(a) (Prohibition of derogation from particular human rights and freedoms – freedom from torture and cruel, inhuman or degrading treatment or punishment); article 45 (Human rights freedom additional to others rights).

- Penal Code: article 224 (surgical operation). This section provides a clear exception to the criminalization of abortion in cases where the termination of pregnancy is necessary to preserve the woman's life.
- Code of Professional Ethics (Medical and Dental Practitioners): The practitioner shall not violate the patient's human rights (article 4) and not deny emergency treatment or health care to a patient (article 8).
- Patient's Charter: article 1 (right to medical care); article 15 (confidentiality and privacy).
- National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights: a patient has the right to a comprehensive abortion care when a severe maternal illness threatening her health (Chapter 4.13). Besides, it's a patient right to receive an adequate post-abortion care on a 24-hour basis. The services are to be provided in all hospitals and health centers where there are doctors, midwives and clinical officers trained in comprehensive abortion care and where the minimum hygienic standards are met.
- National Health Policy.
- Adolescent Health Policy Guidelines and Service Standards (2012).
- National Adolescent Health Policy (2004).
- National Child Policy (2020).
- National Standards and Guidelines for Reducing Maternal Morbidity and Mortality from Unsafe Abortion in Uganda (ATTENTION!! provisionally suspended). Despite having been suspended, the creation of these norms in 2015 indicates a certain recognition by the State that there is a public health problem related to sexual and reproductive rights, especially in the context of unsafe abortions.

## CASE STUDY

- There is a specific and individualizable danger. This is a 16-year-old pregnant teenager who has attempted to take her own life.
- Existence of a certain danger: suicide is a frequent cause of maternal death.
- The risk of harm falls on a valuable and non-substitutable asset: if the pregnancy continues, the risk is death or, in other words, the legal asset at risk is the woman's life. This legal right is protected under article 22 of the Constitution of Uganda. Having a dignified life is about defending one's own existence and to exist with dignity, it involves the right to preserve the physical-psychic and spiritual-moral attributes of the human person. What is at stake are personal decisions, individual ethics and individual values, understanding that each citizen, as an individual person, has the right and the duty to take a position, after honest and understandable information, according to her values.
- The risk is exceptional: losing one's life due to risk of suicide is not a general risk. That is, it is not a risk of the type that should and can be assumed by anyone receiving medical treatment, such as, for example, the risk assumed when receiving anesthesia. Ectopic pregnancy is a severe health condition, the continuation of which places the woman at risk of death. Interventions performed after rupture of the fallopian tube, although they may be life-saving, place the woman at high risk of losing her reproductive capacity, which is considered a loss of quality of life and a direct affectation of the dignity of life. These rights are regulated and recognized as a National Objectives Principles of State Policy (XIV, XX) and by articles 17(c), 21, 22, 24, 32(2), 33, 34 and 41 of the Constitution of Uganda; articles 4, 8, 11, and 34 of the Professional Code of Conduct and Ethics for Medical and Dental Practitioners; articles 1, 2, 15 and 25 of the Patient's Charter; and promoted in the National Health Policy and the National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights; the Judgment of the Constitutional Court Case N° 2 of 1997 (NODPSP can be used in interpreting the Constitution) – human rights treaties can be used as criteria for the interpretation of constitutional rights (ICESCR, CEDAW, The African Charter, Maputo Protocol, Convention on the Rights of the Child).

- A “child” is defined as any person under the age of 18 years, in accordance with the United Nations Convention on the Rights of the Child, Article 2 of the African Charter on the Rights and Welfare of the Child, and Article 257 (1) (c) of the 1995 Constitution of Uganda. The Adolescent Health Policy Guidelines and Service Standards (2012); the National Adolescent Health Policy (2004); and the National Child Policy (2020) recognizes the patient’s right to access to reproductive and maternal health care services and the right to Adolescent-Friendly Health Services.
- The Chapter 4.13 of the National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights states that “people who can get services for termination of pregnancy: (i) severe maternal illnesses threatening the health of a pregnant woman e.g. severe cardiac disease, renal disease, severe pre-eclampsia and eclampsia”, among other circumstances. In this sense, this provision should not be interpreted as an exhaustive list, but rather as an illustrative one since the legislator himself chose to use the abbreviation for the Latin phrase “*exempli gratia*” (“for example”). Thus, any serious disease that endangers the life of the woman can be considered a reason for termination of pregnancy – Considering that the termination of pregnancy would reduce the patient’s risk of death is to perform a woman-centered interpretation of the laws, considering her socioeconomic circumstances and the impact it may have on her physical and mental health to force her to continue with the pregnancy. Thus, protecting the patient’s right to life and health requires recognizing the long-term effects that mental disorders have on a woman’s life, especially when it comes to a child.
- The circumstances must be considered as a risk to the woman’s life and, therefore, the health professional’s actions fall under the provisions of article 224 of the Penal Code.
- In addition, according to the National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights a patient has the right to a comprehensive abortion care when a severe maternal illness threatening her health (Chapter 4.13). Besides, it’s a patient right to receive an adequate post-abortion care on a 24-hour basis. The services are to be provided in all hospitals and health centers where there are doctors, midwives and clinical officers trained in comprehensive abortion care and where the minimum hygienic standards are met.

## CASE 3: SEXUAL ABUSE OF A MINOR UNDER 15

| *“A 12-year-old girl pregnant as a result of sexual abuse”.*

### History

The patient does not report having started menstruation. Her mother brought her to the clinic for severe nausea and vomiting. When she was found to be 12 weeks pregnant, an investigation was opened, and it was found that her stepfather had been molesting her since she was 10.

### Physical examination

Examination shows a patient who is conscious, oriented, and hydrated, with normal hemodynamic signs.

Height 1.42, weight 39 kg.

Blood pressure 105/65 mmHg, heart rate 72 beats per minute. A pelvic examination is not performed because of the history of abuse. Obstetric ultrasonography is ordered.

### Diagnosis

Gestational age of 12 weeks by sonogram.

### Intervention

The option of legal termination of pregnancy is offered under the life exception, and the patient and her mother agree.

### Risk

The population most vulnerable to sexual abuse is adolescents aged 11 to 16, and these crimes usually go unreported. The most frequent victims are girls younger than 15, and in 50% of cases, the abuser is known to the victim.

There is evidence that girls younger than 15 are four times more likely to suffer maternal death in comparison with the 20 to 24 age group. It is also known that girls under 15 have higher rates of anemia, pregnancy-associated hypertension, vaginal infections, postpartum infections, and postpartum complications. In very young girls, feto-pelvic disproportion may occur, increasing the incidence of childbirth complications as well as the proportion of caesarean sections, which are riskier than vaginal birth.

This is compounded by the psychological and emotional effects of years of sexual abuse, lack of psychosocial maturity for motherhood, and risk of unsafe abortion. The girl's situation is serious and urgent, since her life, health, and personal integrity are threatened and at risk.

### **Legal and ethical basis**

- There is specific and individualizable danger: The patient is a 12-year-old girl, pregnant as a result of rape.
- There is real danger: Pregnancies in girls under 15 have higher maternal mortality rates, and pregnancies resulting from rape are associated with greater probabilities of suicide and serious mental illness in general. The risks to mental health in child victims of sexual abuse are severe and have major implications for development of personality.
- The risk of harm concerns a valuable and irreplaceable interest: Continuing with the pregnancy would increase the girl's risk of death for causes directly related to the pregnancy. Furthermore, even in cases where risk of death may be reduced, the risks to quality of life and dignity are not reduced. The physical sequelae of a pregnancy and caesarean section in a 12-year-old girl may be permanent and could affect her reproductive capacity, and the mental health consequences of rape on mental health are permanent. Social consequences, too, are serious, ranging from school dropout and illiteracy to loss of employment opportunities. Single teenage mothers whose pregnancy is the result of rape tend to face serious social marginalization and nearly total lack of social mobility, which constitutes a clear diminishment of their rights to quality of life and life with dignity.
- The risk is exceptional: Rape is a criminal offense that is much more serious when committed against minors. Having to continue with a pregnancy resulting from rape is a disproportionate burden on the victim. It is not the sort of burden that the general public should legally have to tolerate. Therefore, the course of treatment to prevent risk of harm is legal termination of pregnancy.

- Voluntary termination of pregnancy is legal under all national and international laws protecting the rights to life and health and patients' rights.
- Application in the Uganda context
- National standards applicable to the specific case:
- Constitution of the Republic of Uganda: Constitutional objectives XIV(b) (Right to health) and XX (Medical services); article 8(A); article 17(c) (Duties of citizen); article 20 (Fundamental and other human rights and freedoms); article 21(1) (Equality and freedom from discrimination); article 22 (Right to life); article 24 (Human dignity); article 33 (Full and equal dignity of women); article 33(2) (Affirmative action in favour of marginalised group); article 41 (Right to information); article 34 (Rights of Children); article 44(a) (Prohibition of derogation from particular human rights and freedoms – freedom from torture and cruel, inhuman or degrading treatment or punishment); article 45 (Human rights freedom additional to others rights).
- Penal Code: article 224 (surgical operation). This section provides a clear exception to the criminalization of abortion in cases where the termination of pregnancy is necessary to preserve the woman's life.
- Code of Professional Ethics (Medical and Dental Practitioners): The practitioner shall not violate the patient's human rights (article 4) and not deny emergency treatment or health care to a patient (article 8).
- Patient's Charter: article 1 (right to medical care); article 15 (confidentiality and privacy).
- National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights: a patient has the right to a comprehensive abortion care when a severe maternal illness threatening her health (Chapter 4.13). Besides, it's a patient right receive an adequate post-abortion care on a 24-hour basis. The services are to be provided in all hospitals and health centers where there are doctors, midwives and clinical officers trained in comprehensive abortion care and where the minimum hygienic standards are met.
- National Health Policy.

- Adolescent Health Policy Guidelines and Service Standards (2012).
- National Adolescent Health Policy (2004).
- National Child Policy (2020).
- National Standards and Guidelines for Reducing Maternal Morbidity and Mortality from Unsafe Abortion in Uganda (ATTENTION!! provisionally suspended). Despite having been suspended, the creation of these norms in 2015 indicates a certain recognition by the State that there is a public health problem related to sexual and reproductive rights, especially in the context of unsafe abortions.

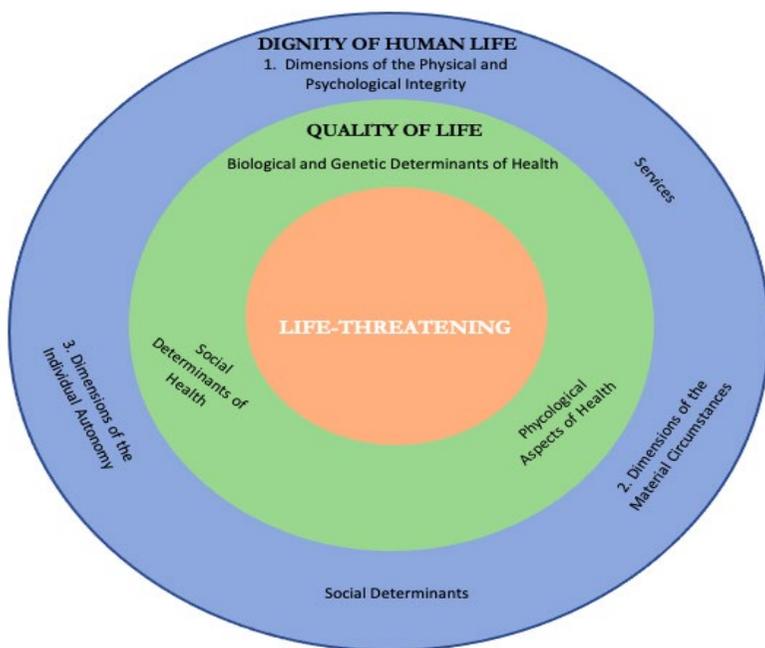
## CASE STUDY:

- There is a specific and individualizable danger. This is a 12-year-old girl who is pregnant as a result of rape.
- Existence of a certain danger: pregnancies in children under 15 years of age have a higher maternal mortality rate and pregnancies resulting from rape are related to a higher probability of suicide and serious mental illness in general.
- The risk of harm falls on a valuable and non-substitutable asset: if the pregnancy continues, the risk is death or, in other words, the legal asset at risk is the woman's life. This legal right is protected under article 22 of the Constitution of Uganda. Having a dignified life is about defending one's own existence and to exist with dignity, it involves the right to preserve the physical-psychic and spiritual-moral attributes of the human person. What is at stake are personal decisions, individual ethics and individual values, understanding that each citizen, as an individual person, has the right and the duty to take a position, after honest and understandable information, according to her values.
- The risk is exceptional: losing one's life due to ectopic pregnancy is not a general risk. That is, it is not a risk of the type that should and can be assumed by anyone receiving medical treatment, such as, for example, the risk assumed when receiving anesthesia. Ectopic pregnancy is a severe health condition, the continuation of which

places the woman at risk of death. Interventions performed after rupture of the fallopian tube, although they may be life-saving, place the woman at high risk of losing her reproductive capacity, which is considered a loss of quality of life and a direct affectation of the dignity of life. These rights are regulated and recognized as a National Objectives Principles of State Policy (XIV, XX) and by articles 17(c), 21, 22, 24, 32(2), 33, 34 and 41 of the Constitution of Uganda; articles 4, 8, 11, and 34 of the Professional Code of Conduct and Ethics for Medical and Dental Practitioners; articles 1, 2, 15 and 25 of the Patient's Charter; and promoted in the National Health Policy and the National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights; the Judgment of the Constitutional Court Case N° 2 of 1997 (NODPSP can be used in interpreting the Constitution) – human rights treaties can be used as criteria for the interpretation of constitutional rights (ICESCR, CEDAW, The African Charter, Maputo Protocol, Convention on the Rights of the Child).

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- The Chapter 4.13 of the National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights states that “people who can get services for termination of pregnancy: (v) rape, incest and defilement”, among other circumstances.
- The circumstances must be considered as a risk to the woman's life and, therefore, the health professional's actions fall under the provisions of article 224 of the Penal Code.
- In addition, according to the National Policy Guidelines and Service

Standards for Sexual and Reproductive Health and Rights a patient has the right to a comprehensive abortion care when a severe maternal illness threatening her health (Chapter 4.13). Besides, it's a patient's right to receive an adequate post-abortion care on a 24-hour basis. The services are to be provided in all hospitals and health centers where there are doctors, midwives and clinical officers trained in comprehensive abortion care and where the minimum hygienic standards are met.



*This diagram illustrates the two dimensions of life placed at risk; Dignity of human life and quality of life. While the two dimensions are related, they need to be looked at with both a medical and legal lens. The quality of life is affected by the biological, psychological and social risk factors and their subsequent negative effects on mental and physical health while the dignity of human life is linked to human rights protection for instance; individual autonomy, access to material conditions, moral and ethical integrity including the right to privacy.*

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