



CEHURD
social justice in health



POSITION PAPER ON THE LEGAL IMPLICATIONS OF THE GUIDELINES FOR CLINICAL DECISION MAKING WHEN PREGNANCY PLACES A WOMAN'S LIFE AT RISK

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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.

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LIST OF ACRONYMS

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

1. INTRODUCTION

CEHURD is an indigenous, non-profit, research and advocacy organization which is pioneering the enforcement of human rights and the justiciability of the right to health. CEHURD focuses its efforts on critical issues of human rights and health systems, including SRHR. Uganda has for long suffered a high number of abortions many of which are unsafe. In 2013, approximately 314,304 abortions were conducted, with approximately 128,682 women receiving treatment for complications related to abortion (Prada et al 2016), the high numbers of unsafe abortions have majorly been due to the restrictive laws and policies on abortion that hinder access to healthcare. CEHURD's experience in the past has been the implementation of the legal defense of the HRM, a model that has proved effective in assisting women to access safe abortion services in a restrictive environment.

Abortion in Uganda is largely restricted and only permitted for preservation of a woman's life.¹ Uganda also has criminal sanctions within the Penal Code Act, Cap 120 which criminalizes the supply of abortifacients, as well as assisting a woman to have an abortion and the woman conducting the process to have an abortion. However, there is no clear definition of the circumstances that fit the criteria of "preservation of the mother's life", which would guide health workers to perform legally accepted abortions.

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. These are potentially applicable in countries with restrictive laws on abortion. This position paper seeks to analyze these guidelines, to see if the same can be applied in Uganda's context.

1. Article 22(2) of the Constitution of the Republic of Uganda, 1995 which states that; "No person has the right to terminate the life of an unborn child except as may be authorised by law" and Section 224 of the Penal Code Act, Cap 120 which states 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."

a. 1.1 Objectives

To conduct an analysis of the "Guidelines for clinical decision-making when pregnancy places the woman's life at risk" from a legal standpoint.

b.

To explore the feasibility of adopting and using these guidelines within Uganda's context

1.2 Rationale

Unsafe abortion continues to be a major contributor of maternal mortality and morbidity in Uganda particularly amongst teenage girls and young women². Though safe abortion in Uganda is permissible in some incidences³, the laws and policies remain widely restrictive and ambiguous limiting access and provision of safe abortion services by girls, women, and health care providers respectively⁴. A 2013 study conducted by the Guttmacher Institute, Makerere School of Public Health and the Center for Health, Human Rights & Development (CEHURD), estimated 14 percent of all pregnancies ended in abortions, translating into an abortion rate of 34 per 1,000 women during 2010 – 2014, the highest rate in the region⁵.

Furthermore, 52% of pregnancies are reportedly unintended with the majority ending in unsafe abortion⁶ despite many going unreported or undocumented⁷. The restrictive and unclear policy and legal environment in Uganda remain a limitation and unfavorable to access of not only safe abortion⁸, but the wider maternal health services despite increasing need for these services.⁹ Majority of the health professionals are reportedly afraid of providing safe abortion services to save women's lives for fear of being convicted of criminal acts and the resulting legal consequences¹⁰ and only restrict themselves to providing the legally accepted post abortion care which is usually provided late.

Uganda is amongst the countries with low levels of contraceptive uptake, limited access to sexual and reproductive health information, medical and health services¹¹, resulting in negative maternal health outcomes including unintended pregnancies resulting in unsafe abortion. These conditions have been exacerbated by the Covid-19 pandemic and its resulting effects particularly affecting vulnerable populations including but not limited to adolescent girls and young women. Due to the plethora of reports and evidence of increased rates of teenage pregnancies, unintended pregnancies¹²,

2. Cleeve, A., Faxelid, E., Nalwadda, G., & Klingberg-Allvin, M. (2017). Abortion as agentive action: reproductive agency among young women seeking post-abortion care in Uganda. *Culture, health & sexuality*, 19(11), 1286-1300. <https://www.tandfonline.com/doi/full/10.1080/13691058.2017.1310297>

3. National Policy Guidelines & Services Standard for Sexual & Reproductive Health& Rights, 2012

4. The State of Sexual Reproductive Health and Rights in Uganda Emerging Issues. Submission to the universal periodic review of Uganda: Second cycle of the Twenty sixth session of the UPR Human rights council 31 October – 11 November 2016

5. Fact Sheet: Abortion and Postabortion Care in Uganda, 2017. <https://www.guttmacher.org/fact-sheet/abortion-and-postabortion-care-uganda#>

6. Singh, S., Prada, E., Mirembe, F., & Kiggundu, C. (2005). The incidence of induced abortion in Uganda. *International family planning perspectives*, 183-191.

7. Polis, C. B., Lutalo, T., Wawer, M., Serwadda, D., Kigozi, G., Nalugoda, F., ... & Gray, R. (2009). Coerced sexual debut and lifetime abortion attempts among women in Rakai, Uganda. *International Journal of Gynecology & Obstetrics*, 104(2), 105-109.

8. Ibid 4

9. Paul, M., Gemzell-Danielsson, K., Kiggundu, C., Namugenyi, R., & Klingberg-Allvin, M. (2014). Barriers and facilitators in the provision of post-abortion care at district level in central Uganda—a qualitative study focusing on task sharing between physicians and midwives. *BMC health services research*, 14(1), 1-12.

10. Olson, R. M., & Kamurani, S. (2017). Barriers to safe abortion access: uterine rupture as complication of unsafe abortion in a Ugandan girl. *Case Reports*, 2017, bcr-2017.

11. Ooms, G. I., Kibira, D., Reed, T., van den Ham, H. A., Mantel-Teeuwisse, A. K., & Buckland-Merrett, G. (2020). Access to sexual and reproductive health commodities in East and Southern Africa: a cross-country comparison of availability, affordability and stock-outs in Kenya, Tanzania, Uganda and Zambia. *BMC public health*, 20(1), 1-14.

12. Wado, Y. D., Sully, E. A., & Mumah, J. N. (2019). Pregnancy and early motherhood among adolescents in five East African countries: a multi-level analysis of risk and protective factors. *BMC pregnancy and childbirth*, 19(1), 1-11.

rape and defilement, provision and access to safe abortion and post abortion care services cannot be overstated. Though many cases go unreported¹³, it is contemporary knowledge that many mothers and young women seek abortion services at any cost, thus resorting to clandestine and unsafe sources.¹⁴

It is against this background that CEHURD reviewed the Latin American guidelines for clinical decision making when pregnancy places the woman's life at risk, with the aim of localizing best practices, processes and guidelines for clinical decision making when pregnancy places a woman's life at risk in Uganda.

1.3 Methodology

We utilized qualitative research methods including desk and document reviews, subject matter experts' consultations, formal and informal interviews, committee interviews, and focus group discussions.

Desk Review

The desk review involved an analysis of the "Guidelines for clinical decision making when pregnancy places the woman's life at risk", developed in reference to Latin America, as well as analysis of literature on relevant health and legal frameworks at the national, regional, and international levels. Literature reviewed included articles from peer-reviewed journals and national reports.

Subject Matter Expert Consultations (Discussions)

Consultations were conducted with two categories of stakeholders during inception meetings and writing workshops held with members from the medical and legal fraternities in Uganda. From the medical fraternity, we consulted and worked with health workers from different medical facilities and institutions, as well as from various medical bodies. Health workers were responsible for sharing their experiences and the parameters they use to decide that a woman's life is at risk within the clinical setting. The lawyers provided input on when pregnancy can be legally considered as placing a mother's life at risk, more importantly with focus on the Ugandan laws, policies, and context.

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 suggest a "Ugandan" version of the guidelines

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13 ibid 7
14 ibid 2

2. BACKGROUND TO THE CLINICAL GUIDELINES AND THEIR APPLICABILITY IN LATIN AMERICA

The development of these guidelines¹⁵ has its roots in the high maternal mortality rates in the Latin America region¹⁶, coupled with the high number of teenage pregnancies. Among the major causes of the high maternal mortality in Latin America is the practice of unsafe abortions, which are commonly conducted majorly due to restrictive laws and policies, resulting in clandestine activity.¹⁷ Furthermore, the lack of timely access to safe abortion services is a cause of maternal mortality, alongside many others.¹⁸

According to the guidelines, most countries in the Latin American and Caribbean settings have criminal laws against voluntary abortion that 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, coupled with non-respect for women’s rights. 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.

15. Briozzo L, Gómez P.I., Acosta H et al, Guidelines for clinical decision making when pregnancy places the woman’s life at risk, 2018.

Available at: https://www.ipfwhr.org/wp-content/uploads/2019/01/Causal-Vida_IPFVHR.pdf

16. <https://www.who.int/health-topics/maternal-health> last visited on 10th June 2021

17. Guttmacher Institute. Induced abortion worldwide, 2016 [Fact Sheet]. Available at: www.guttmacher.org/fact-sheet/facts-induced-abortion-worldwide. Last visited on 10th June 2021

18. ASHFORD, L. Hidden suffering: disabilities from pregnancy and childbirth in less developed countries, Population Reference Bureau. 2002. Available at: <https://www.prb.org/wp-content/uploads/2002/08/HiddenSufferingEng.pdf>. Last visited on 10th June 2021.

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.

2.1 Implementation of the guidelines

The authors describe the ways in which the guidelines can be used, starting with a risk assessment that should be done, preferably by a team of health workers together with other specialists in social work, mental health, and related disciplines. It also gives examples of what data should be collected and it highlights case studies.

2.2 Assessing pregnancy-related risk to life

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 a holistic approach to risk analysis, including two broad areas:

- a) Identification of risk factors
- b) The dimension of life that is placed at risk

They urge health workers to be aware that risks to life are often interconnected, thus the need for a comprehensive approach to decision making. Assessing pregnancy related risk to life should not have the health worker looking at things in isolation but should assess risk based on biological risk factors, psychological risk factors and social risk factors. Table 1 summarizes the range of risk factors as considered by the guidelines and why they are considered so. However, this list is not exhaustive, but rather a range of examples to illustrate the various risk factors. In reality, there shall be many more aspects to consider.

2.3 TABLE 1: Risk factors that put the life of the girl or woman at risk

Risk factor	Examples	Effects
1. Biological risk factors	Without pre-existing illnesses but is at risk due to pregnancy circumstances e.g., girls below 15 with immature physical and reproductive systems and psychological development.	Physical ailments Loss of life of mother or fetus Morbidity May trigger mental health risks for the pregnant woman or girl
	Develops a condition during pregnancy that causes health complications e.g., hypertension but no pre-existing illness.	
	Pre-existing illness that is worsened by pregnancy e.g., heart disease.	
	Pre-existing illness whose treatment is limited by pregnancy or pregnancy is a contraindication e.g., cancer	
2. Psychological risk factors	Pre-existing mental illness that worsens, or may worsen, with pregnancy.	Leads to suicide and self-harm Depression Stress Panic disorders, anxiety Affects physical health Negative effects on quality of life Isolation Stigma Increased substance abuse
	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 as a result of sexual violence.	
	Pregnant in a context that threatens her dignity or quality of life e.g., forced to keep an unwanted pregnancy	

3. Social risk factors	Poverty related malnutrition	Cause or increase physical health problems Fetal malformation Cause or increase mental health problems Disgrace, stigma and dishonor Depression Suicide Murder Greater risks for poor women
	Bad 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)	

2.4 Dimensions of life placed at risk

The assessment of whether the pregnancy places the life of the girl or woman at risk also includes identification of which dimension of life exactly is placed at risk. While the two dimensions are related, they also need to be looked at with both a medical and legal lens. The dimensions are the quality of life and dignity of life.

2.4.1 Situations creating risk to quality of life

The guidelines cite a description of quality of life by Palomba who refers to it as “enjoying “objectively” good life conditions and a high degree of “subjective” well-being, including, in addition to the fulfillment of the individual’s needs, their collective fulfillment through social policy”¹⁹. It is a concept linked more to the health care side of things. Quality of life is affected by the biological, psychological, and social risk factors already discussed and their subsequent negative effects on mental and physical health.

2.4.2 Situations creating risk to dignity of life

The issue of dignity is principally linked to human rights protection, specifically:

19. PALOMBA, Rosella. Calidad de Vida: conceptos y medidas, Institute of Population Research and Social Policies, Workshop by the Economic Commission for Latin America and the Caribbean, 2002. Available at: www.cepal.org/celade/agenda/2/10592/envejecimientoRP1_ppt.pdf.

- Autonomy to live as one wishes and build their desired life: This can be disrupted by sexual violence for instance.
- Accessing material conditions that help them live well, without deprivation: This includes “access to economic and material resources such as housing, food or healthcare, as well as intangible resources such as family and social support networks”, jobs and job security and going to school. There is also a risk of stigma due to pregnancy.
- Integrity, that is living a life free of humiliation, with moral and physical integrity including the right to privacy: The guidelines state that “the integrity dimension must always be assessed taking into account the woman or girl’s perception, as well as all the elements of her identity, such as her ethnic or racial group and her physical or mental disability status”.

3. CONTEXT OF SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN UGANDA

3.1 Fertility and family planning in Uganda

Uganda has a high fertility rate of about 5.4 children per woman²⁰, although this has reduced over the years to 4.8 children per woman²¹. 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 child birth, with the figure higher in rural areas, amongst those with lower education and those in lower wealth quintiles.²² Equally, 66% of all new HIV infections are contracted by adolescent girls yet only 13.1% use a modern method of contraception.²³

3.2 Context of abortion in Uganda

In Uganda, abortion is restricted by law. Furthermore, it is associated with a lot of stigma, including from religious leaders,²⁴ 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

20. Uganda Demographic Health Survey, 2016

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

22. Supra

23. The Uganda Bureau of Statistics National Household Survey Report, 2019/2020

24. 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

young women, or a human rights discourse with debate on the woman's right to life and health and the unborn fetus's right to life, all supported by legal and medical discourses.²⁵ 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.²⁶ 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.²⁷ 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.²⁸ Indeed, although Uganda's maternal mortality ratio has reduced over the years, it remains fairly high at 336 deaths per 100,000 births, with unsafe abortions contributing over 8% to these figures.²⁹ Other outcomes include perforation, sepsis, severe vaginal bleeding, uterine rupture and others.³⁰

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.³¹

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

26. *Ibid*

27. 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.

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

29. Uganda Demographic Health Survey, 2016

30. *Ibid*. Note 15

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

3.3 The Legal framework on abortion in Uganda

Definition of Abortion

According to the Webster's New World Medical Dictionary 3rd Edition, an abortion is defined as the "Premature exit of the products of the fetus, fetal membranes, and placenta from the uterus"

There are two types of abortion and these are:

- **Spontaneous Abortion:** this is a natural process and is what is usually called a miscarriage
- **Induced Abortion:** This is where a woman is assisted to abort and it can be through using medication (for instance abortifacients) or other substances that cause the body to expel the fetus or through surgical procedure that removes the contents of the uterus.

3.4 Analysis of Legal provisions on abortion

The international, regional and national legal framework on abortion in Uganda details the laws and policies that govern the provision of abortion services. However, it is worth noting that provision of abortion in Uganda is highly restricted and this is because 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(2) prohibits the deprivation of the life of any person including a fetus, except as authorized by law.³²

However, 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 central law where provisions on abortion can be found is the Penal Code Act Cap 120 that 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 to induce an abortion.³³ The key feature cutting across these criminal provisions is intent. Under each of the provisions, it has to be established

32. Article 22 of the Constitution of the Republic of Uganda on the Protection of right to life (1) No person shall be deprived of life intentionally except in execution of a sentence passed in a fair trial by a court of competent jurisdiction in respect of a criminal offence under the laws of Uganda and the conviction and sentence have been confirmed by the highest appellate court.

33. Section 141 of the Penal Code Act, Cap 120. Attempts to procure abortion. Any person who, with intent to procure the miscarriage of a woman whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means, commits a felony and is liable to imprisonment for fourteen years. Section 142 of the Penal Code Act, Cap 120. Procuring miscarriage. Any woman who, being with child, with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means, or permits any such things or means to be administered to or used on her, commits a felony and is liable to imprisonment for seven years. Section 143 of the Penal Code Act, Cap 120. Supplying drugs, etc. to procure abortion. Any person who unlawfully supplies to or procures for any person anything, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman, whether she is or is not with child, commits a felony and is liable to imprisonment for three years.

that there was an intention to induce an abortion and it is worth noting that spontaneous abortions are not criminally punishable in Uganda. Equally post abortion care is also not criminally punishable in Uganda.

While the Penal Code largely criminalizes abortion, it provides a defense for those charged under these offences in Section 224 as below;

“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.”

This section is what is currently used to justify providing legal abortion in Uganda and is strictly available to both the person providing the abortion and the person who gets the abortion. The section is further expounded in the National Policy Guidelines for Sexual and Reproductive Health Services of 2006. These create a threat to life exception: that an abortion will be permitted to be performed in good faith with reasonable skill and care by a health worker on a pregnant woman if her pregnancy places her life at risk and this exception is an acceptable defense to criminal prosecution. Key to note also is the consideration of all circumstances of the case where an abortion is induced meaning that a pregnant woman should be looked at holistically in her given environment as an assessment is made on whether her life is at risk.

The basis for this defense is contained in R vs. Bourne [1939] 1 K. B. 687, 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 Ministry of Health developed the National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights 2006, which provide guidance for the management and prevention of unsafe abortion and highlight several considerations for when a person can access comprehensive abortion care. These guidelines show who can perform an abortion, where an abortion can be performed and why an abortion should be performed. The grounds set down to perform an abortion are as below:

1. Severe maternal illnesses threatening the health of a pregnant woman e.g., severe cardiac disease, renal disease, severe pre-eclampsia and eclampsia
2. Severe foetal abnormalities which are not compatible with extra-uterine life e.g., molar pregnancy, anencephaly
3. Cervical cancer
4. HIV-positive women requesting for termination under a) and b) above
5. Rape, incest and defilement

While these medical grounds are permissible in the guidelines, it is worth noting that some grounds like sexual violence are not expressly recognized in section 224 of the Penal Code Act which is the guiding law but this gives guidance that when assessing the threat to life health workers need to go beyond imminent death and include psychological risks caused by sexual violence. 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 SRH 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.

Uganda is a signatory to several international instruments that guarantee the rights to life, health and the right to sexual and reproductive health. A case in point is article 12 of the International Covenant on Economic Social and Cultural Rights (ICESCR) which recognizes the *“right of everyone to the enjoyment of the highest standard of physical and mental health”*. This right includes *“the right to control one’s health and body, including sexual and reproductive freedom,”* which “requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health”³⁴

The right to sexual and reproductive health is an integral part of the right to health enshrined in Article 12 of the ICESCR and is also reflected in other international human rights instruments, SRHR guarantee women and girls access to safe abortion services and quality post-abortion care, including by training health-care providers; and to respect the right of women to make autonomous decisions about their sexual and reproductive health.³⁵ The same thoughts are reflected in the Maputo protocol, which Uganda signed onto, where Article 14 entreats state parties to ensure that the right to health of women,

34. CESCR. (2000). General Comment No 14: The Right to the Highest Attainable Standard of Health (Article 12).

35. General comment No. 22 of 2016 on the right to sexual and reproductive health (article 12 of the international covenant on economic, social and cultural rights)

including sexual and reproductive health is respected and promoted, this includes protecting the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.³⁶

Although Uganda placed a reservation on article 14(2)(c) of the Maputo protocol, putting forward that abortion shall be applied as per the domestic laws of Uganda, guidance is provided on the considerations to be made when determining whether a woman can access a safe and legal abortion and this includes going beyond potential physical injuries in the short and long term, to include mental suffering, which can be exacerbated by the disability or precarious socioeconomic status of the woman.³⁷ Similarly the reasons put forward by the woman seeking an abortion must be taken into account, and States are required to ensure that the legal frameworks in place facilitate access to medical abortion when the pregnancy poses a threat to the health of the pregnant woman.

Uganda also signed onto the Convention on Elimination of all forms of Discrimination against Women without reservation which under Article 12 requires state parties to eliminate discrimination against women in their access to health-care services throughout their life cycle, particularly in the areas of family planning, pregnancy and confinement and during the post-natal period. This obligation requires the state to among others

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

All these laws recognize the right to life and dignity which is about defending one’s own existence and to exist with dignity involves the right to preserve the physical, psychological and spiritual-moral attributes of the human person. They also accord rights to a patient seeking care and obligations on a health service provider attending to a patient.

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36. Article 14(2)(c) Protocol to the African Charter on human and peoples’ rights on the rights of women in Africa

37. General comment No. 2 on article 14 of the Protocol to the African Charter on human and peoples’ rights on the rights of women in Africa

Patients' Rights

Right to access correct information

Right to Privacy

Right to Confidentiality

Right to bodily autonomy

Right to medical care

Provider Obligations

- a. Do no harm
- b. Act professionally
- c. Provide privacy
- d. Obligation to provide care
- e. Provide correct and accurate information
- f. Non-judgmental
- g. Confidentiality

3.5 Using the Harm Reduction Model and the Life at Risk Model to Address Unsafe Abortion

The legal and regulatory framework on abortion in Uganda is largely restrictive, requiring health service providers to implement the HRM. The HRM operates within the existing legal framework on abortion to mitigate the harmful consequences related to unsafe abortion that impact women and girls of reproductive age in Uganda. The HRM recognizes that clients have rights and providers have obligations as recognized in the Code of Professional Ethics for health workers and the Patient's Charter.

The Harm Reduction Model (HRM) has been defined as an evidence-based public health and human rights framework that prioritizes strategies to reduce harm and preserve health in situations where policies and practices prohibit, stigmatize and drive common human activities underground.³⁸ Originally developed to prevent the spread of HIV/AIDS by encouraging the exchange of used syringes for new ones to limit syringe sharing, the HRM was re-conceptualized by the Uruguayan organization Iniciativas Sanitarias to prevent unsafe abortion in what has been referred to as the Harm and Risk Reduction Model,³⁹ which we now call the HRM.

The HRM seeks to prevent unsafe abortion by ensuring that women and girls of reproductive age facing an unintended pregnancy receive comprehensive information and care so that they can make autonomous decisions. It also mobilizes health professionals so that they become agents of change, training them on medical

38. <https://www.ibisreproductivehealth.org/sites/default/files/files/publications/Hyman%20A%20et%20al.%20Miso%20in%20women's%20hands%20a%20harm%20reduction%20strategy%20for%20unsafe%20abortion.%20Contraception.%20Feb%202013.pdf> last visited on 18th March 2021

39. Labandera A, Gorgoro M, Briozzo L, Implementation of the Risk and Harm reduction strategy against unsafe abortion in Uruguay: From a university hospital to the entire country. *Int J Gynecol Obstet* 2016; 134 (Suppl. 1): S3-6

ethics and clients' right to information, health and confidentiality, and by providing opportunities for them to champion efforts to reduce the harm caused by unsafe abortions.

Given the restrictive environment, health service providers including nurses and midwives are often fearful of providing accurate information to women and girls of reproductive age concerning procuring a safe abortion, however, the constitution allows them the right to exercise their profession,⁴⁰ whose backbone is the provision of information. Given the circumstances, it becomes prudent to identify opportunities for the provision of safe abortion alternatives without putting the lives of women and the safety of service providers at risk considering the legal framework. The HRM is an alternative to secure both.

However, the HRM is limited in a way because it discourages health workers from providing legal abortion services, As already mentioned, this is majorly because safe abortion services are restricted within the law and are only allowed to preserve the life of a woman, which definition is ambiguous and is often misconstrued by health workers. Within the HRM therefore, health workers are obliged to only provide information prior to an abortion or to provide post abortion care. This means that often women are forced to induce an abortion on their own without the support of a health worker, which increases the chances of the abortion becoming unsafe or delaying care where complications happen.

The clinical guidelines for decision making when pregnancy places the woman's life at risk (which this paper assesses) provide an opportunity for health workers to provide legal abortions by clearly interpreting the exception of preserving the life of a woman. In this way they work to increase the points of intervention for a health worker while providing comprehensive abortion care.

While the HRM has demonstrated to be an acceptable and effective alternative to prevent unsafe abortion in restrictive settings, the model should not replace efforts to provide legal abortions by clearly interpreting available exceptions in the regulatory frameworks. For instance, the exception of preserving the life of a woman. Legal abortion services ensure both providers and clients feel supported and opens an opportunity for a more comprehensive care and monitoring of service quality.

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40. Article 40 (2) of the 1995 Constitution of the Republic of Uganda (as amended)

4. A COMPARATIVE ANALYSIS OF THE CLINICAL GUIDELINES

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. Some countries in the Latin America and Caribbean have laws similar to Uganda where abortion is only allowed when a 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 social, biological and psychological variables are analyzed and form a broader construction of what places a woman's life at risk. This is not comprehensively set out in the Ugandan context. In this paper, we attempt to place these risk factors within the laws, policies and practices on abortion in Uganda, to gauge their adaptability for use in our context.

In assessing the biological, psychological and social risks we have to keep in mind that Women of reproductive age refers to all women aged 15–49 years⁴¹ which includes adolescents. Unfortunately, the age of majority is generally recognized in national and international law to be 18 years,⁴² 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.⁴³

For a patient whose physical condition does not enable her to give written consent, the procedure should be performed to save life.⁴⁴ This would affect the assessment of the life at risk since it has to be done in consultation with the parent(s) or guardians of the minor who present an extra hurdle to access sexual and reproductive health services.

4.1 Biological risk factors

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.

41. Reproductive health indicators: guidelines for their generation, interpretation and analysis for global monitoring – WHO 2006 at page 9

42. Section 2 of the Children Act Cap 59 as amended in 2016 which says "A child is a person below the age of eighteen years"

43. Ministry of Health National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights

44. Supra.

Considerations for biological risk in Uganda

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

Considerations for biological risk 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

The National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights 2006 provide guidance for the management and prevention of unsafe abortion and highlight several medical grounds / indications on which a person can access comprehensive abortion care. These are severe maternal illnesses threatening the health of a pregnant woman e.g., severe cardiac disease, renal disease, severe pre-eclampsia and eclampsia; severe foetal abnormalities which are not compatible with extra-uterine life e.g., molar pregnancy, anencephaly; and cervical cancer.

Equally, the practice among health workers is that abortion is considered as part of patient management when managing a pregnant person, when assessing life at risk, consideration is made for existing conditions that are aggravated by pregnancy as well as conditions that are brought on by pregnancy ultimately the greatest consideration is placed on whether a pregnant person is in danger of imminent death because of the pregnancy. The consideration is majorly based on biological considerations and very few health workers actually consider mental health and social conditions. Even the guidelines that establish these considerations for making an assessment of life

at risk do not provide for mental health and social risks of a pregnancy. From this it is clear that the biological risk factors assessment can be used in Uganda to assess pregnancy related risk to life except where the risk is in mental health.

4.2 Psychological risk factors:

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 as a result of 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
- Rape, incest and defilement
- Good faith

From the Penal Code Act and 2006 Guidelines, the circumstances and patient's state at the time of the abortion are to be considered. Specifically, instances of sexual violence are mentioned, which means that psychological risk factors which result into suicide, anxiety, stress, depression, panic disorders, amongst others can be considered if a health worker can demonstrate that the psychological risk factors will result into physical harm.

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

The practice amongst mental health practitioners is that abortions can and are currently being carried out in Uganda for psychological reasons usually on grounds that anti-psychotic medications are often incompatible with pregnancy. The effects of the medication usually negatively affect the fetus and a pregnant woman cannot be sustained on such medication so she has to either choose the pregnancy or the medication. Also, in instances of substance abuse an abortion is recommended usually because of the effects of the substance on the fetus and also because of the quality of life that the child will have since they may suffer from developmental delays and fetal malformations.

That when assessing a pregnant woman to determine if she needs an abortion based on psychological reasons the consideration is placed on a person's overall wellbeing asking whether they are more likely to hurt themselves or others because of the pregnancy and whether the pregnant person can function well within society even with the pregnancy. Such a decision is made in a triage considering the views and assessment of the pregnant person, the caretaker and the psychologist or psychiatrist who should be able to objectively advise. The levels of decision making include considering whether the pregnant person is able to independently care for themselves and look after the child, if not who will look after this child.

One of the challenges highlighted was that mental health is struggling to be recognized as a medical discipline taken seriously in Uganda and many health workers do not take into account the mental well-being of a pregnant woman when making an assessment of a pregnant woman, so the nexus between mental health and pregnancy is largely little understood. Considering the fact that a full psychological assessment is needed to determine the mental condition of a person like depression, suicidal tendencies, anxiety etc to determine an appropriate intervention, the cadre of a health worker who can make this assessment becomes important.

However, several health workers we interacted with noted that while many health workers are trained from medical school to diagnose a mental condition, few are willing to take the time to consider psychological risks because the health system is overstretched and they do not have the time. Another challenge is that gynecologists and obstetricians are skeptical to use psychological considerations as grounds for an abortion.

4.3 Social risk factors

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
- Good faith

There is limited guidance from the laws and policies on when considerations of social risk can be used to procure an abortion except in the Penal Code Act whose provisions require having regard to the patient's state at the time and all circumstances of the case. We do recognize that Article 24 of the

Considerations for social risk under Latin American guidelines

- Poverty related malnutrition
- Bad 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)

Constitution guaranties the right to dignity and freedom from cruel, inhuman and degrading treatment which can be interpreted as being allowed to live a dignified and quality life and this can be used to justify social risks. The practice of health workers though is that social risks are only considered when they exacerbate an existing biological or psychological risk to assess whether pregnancy places a woman's life at risk but not independently.

5. RECOMMENDATIONS AND CONCLUSION

1. This paper notes that 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. We therefore recommend that mental health and reproductive health practitioners 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.
2. We also note that the breadth of assessment required by the Latin American guidelines requires knowledge of the law and we therefore recommend that health workers be oriented on making such an assessment right from medical school.
3. There was also general consensus that justifying an abortion based on social risks with Uganda's current legal, policy and political environment would be challenging especially for health workers. We therefore recommend that the social risks be noted (where they exist) when they exacerbate or accompany biological and psychological risks to build evidence to support the social risk standing alone.
4. Ministry of Health to develop guidelines for when pregnancy places a woman's life at risk with the aim of saving the lives of women/young girls by expanding the scope of legal and safe abortion services. This would also provide service providers an authoritative standpoint when assessing physical, mental and social risks to life.

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