PROPOSALS FOR ABORTION LAW REFORM IN UGANDA

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CEHURD
social justice in health

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EXECUTIVE SUMMARY

Uganda's maternal mortality ratio (MMR) remains persistently high, at 336/100,000 live births. In 2013, an estimated 314,304 Ugandan women risked their life and health by inducing abortion, a 7% increase on the 2003 estimate. A maternal and perinatal death review found in 2012 that unsafe abortion was among biggest contributors to preventable maternal mortality within the health facilities assessed.

Stigma, negative attitudes and religious values contribute to the high incidence of mortality and morbidity due to unsafe abortion by stifling discussion and programs whilst fueling legal restriction to safe abortion in Uganda. Across the region, a wave of legal reforms has expanded grounds for access to abortion in Rwanda, Ethiopia, Mozambique, South Africa, and Sierra Leone.

The African Commission rolled out a campaign to decriminalize abortion in Africa in 2015. Experience indicates that where there are more enabling laws for access to safe and legal abortion, less women and girls die due to unsafe abortion.

In a bid to bench mark some of the best practices of the various countries and also leverage the interventions of the African Commission, CEHURD undertook a comparative analysis study on the various countries across the region that have reformed their abortion laws as a way of building a case for the abortion law reform options that are available to Uganda.

This paper attempts to provide a rationale for reforming Uganda's abortion law by examining the extent to which the country's laws comply with human rights, gender equality and international law obligations. The paper explores the options for legal reform and synthesizes lessons from other African countries.

Key conclusions and recommendations for law makers and other actors:

- Prevent religion from influencing governance;
- A civil society be well-organized to play a role in the reform process;
- Sensitize medical practitioners about problems related to unsafe abortion;
- Recognize the ineffectiveness of legal prohibition of abortion;
- Utilize Article 33 of the Constitution and international human-rights conventions and other instruments upholding women's rights;
- Build on existing government policies on reproductive health and population that reveal the pre-existing official position on abortion.

ABBREVIATIONS AND ACRONYMS

CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CEHURD	Centre for Human Rights And Development
D&C	Dilation and Curettage
HC	Health Center
ICPD	International Conference on Population and Development
IPAS	International Pregnancy Advisory Services
MOH	Ministry of Health
MVA	Manual Vacuum Aspiration
NGO	Non-Governmental Organisation
SGBV	Sexual and Gender Based Violence
SRH	Sexual and Reproductive Health
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UN	United Nations
UNICEF	United Nations Children's Fund
UPE	Universal Primary Education
UPF	Uganda Police Force
USE	Universal Secondary Education

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1. THE CURRENT POSITION OF THE LAW AND PRACTICE IN UGANDA

1.1 The Constitution

The Uganda Constitution provides in Article 22 that *"[no] person has the right to terminate the life of an unborn child except as may be authorised by law."*[1]

It has been argued that:

> Contrary to popular belief, article 22(2) of the Constitution does not prohibit abortion…. This provision does not preclude access to abortion. Instead, it merely stipulates that there is no right on the part of any person – whether the provider or the pregnant woman – to terminate "the life of an unborn child" in the absence of a law permitting them to do so…Uganda does in fact have such a law: section 224 of the Penal Code.[2]

It should be noted that the Odoki Commission, which collected views to inform the constitution-making process, did not say anything about abortion in its report.[3] It may therefore be assumed that the discussion that gave rise to Article 22 came up during debates in the Constituent Assembly select committee. As such, it is not possible to definitively ascertain what the views of the Ugandan public were at the time of making the Constitution, as the view of the delegates cannot necessarily be said to be the views of the people.

Article 22 of the Constitution, in addition to restricting abortion, provides protection for the right to life. However, the other side of it is that forcing women to resort to life-threatening, unsafe abortions, due to restrictive abortion laws or a lack of access to safe abortion services, is a violation of their right to life. Similarly, a failure to ensure the availability and accessibility of quality post-abortion care, which is an emergency, life-saving service, violates women's right to life.[4]

1 Article 22(2) of the Constitution of Uganda 1995.

2 Centre for Reproductive Rights (2012) *A Technical Guide to Understanding the Legal and Policy Framework on Termination of Pregnancy in Uganda,* https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/crr_UgandaBriefingPaper_v5.pdf

3 The report of the Commission is available at http://www.constitutionnet.org/sites/default/files/merged_ccreport_missingchaps7-14_and24.pdf

4 Centre for Reproductive Rights (2012), above.

Article 24 of the Constitution concerns "respect for human dignity and protection from inhuman treatment" and states that "*no person shall be subjected to any form of torture or cruel, inhuman or degrading treatment or punishment*." This provision could be used to argue that denying post-abortion care or safe and legal abortion services in circumstances where the pregnancy may be a threat to a woman's life, physical health, or mental health – particularly in cases of rape, incest, or severe foetal anomaly – violates her right to be free from torture and cruel, inhuman, and degrading treatment in line with the decision of the UN Human Rights Committee in *KL v. Peru*,[5] discussed further below.

Article 32(2) prohibits "*laws, cultures, customs and traditions which are against the dignity, welfare or interest of women… or which undermine their status…*" It has been argued that this article offers strong legal support for arguments in favor of decriminalizing abortion in Uganda because laws criminalizing abortion violate women's right to dignity. In addition, by leaving women with little recourse, and forcing them to resort to unsafe abortion, which often leads to disability or death, such laws are harmful to women's welfare and interest. As such, the Penal Code provisions criminalizing abortion could be understood as prohibited by the Constitution under article 32(2).[6]

It could also be argued that Article 33(3) requires the government to ensure women's access to safe abortion services under the law, as it obligates the state to make certain that women's "natural maternal functions" and "unique status" is protected. Only women can get pregnant and therefore may need access to safe and legal abortion. Its absence may render them vulnerable to violations of their rights, including their rights to life and health.[7]

Initially, efforts at Public Interest Litigation based on the above Constitutional provisions were not successful. In *Center for Health Human Rights and Development and others v Attorney General of Uganda*,[8] the Constitutional Court ruled that a claim that the failure of the state to provide necessary health services had led to preventable maternal deaths was not justiciable because such a claim raised a 'political' as opposed to a justiciable question.

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5 *KL v. Peru (United Nations Human Rights Committee)*, https://www.reproductiverights.org/case/kl-v-peru-united-nations-human-rights-committee

6 As above. See also Ngwena C. (2014) *Using Human Rights To Realise Access To Safe, Legal Abortion In Uganda, The State's Obligation to Implement National Abortion Law,* http://www.cehurd.org/wp-content/uploads/downloads/2014/02/abortion-and-human-rights-DP-No1.pdf

7 See Ngwena and Centre for Reproductive Rights, above.

8 Constitutional Petition No 16 of 2011 (2012)

A ray of hope is seen in the Supreme Court decision in petition 16 on October 30, 2015, in an appeal against the above ruling. The Supreme Court found that the Constitutional Court wrongly dismissed the 2012 petition and should therefore hear it on its merit. This decision quashes the political questions doctrine as a defence against justiciability of rights of an economic social and cultural nature.

1.2 The Penal Code Act

The Penal Code Act states that it is an offence for a person to procure the miscarriage of woman or to attempt to procure the miscarriage of a woman.[9] Similarly, it is an offence for a woman to procure her own miscarriage.[10] Lastly, it is an offence for a person to supply or procure for a person anything knowing that it is intended to be unlawfully used in procuring the miscarriage of a woman.[11]

Section 212 of the Penal Code concerns the crime of "killing an unborn child." This is an act defined as occurring at the instance "*when a woman is about to be delivered of a child*." The term "unborn child" could therefore be interpreted as referring solely to a foetus that is "about to be delivered."

One interpretation of Section 212 is that it provides for the conviction of a person who destroys a child in the process of birth, in circumstances where it could not be proved that the child had completely proceeded in a living state from its mother's body, to be under the law, a person capable of being killed.[12]

Section 212 should be read together with section 197, which concerns "when a child is deemed a person." It states that:

> "*A child becomes a person capable of being killed when it has completely proceeded in a living state from the body of its mother, whether it has breathed or not, and whether it has an independent circulation or not, and whether the navel string is severed or not*."

Section 224 of the Penal Code absolves persons of criminal liability if they perform, in good faith, a surgical operation on an "unborn child" in order to preserve the pregnant woman's life.[13]

9 See ss. 141and 142 of Cap. 120

10 See s. 142 of Cap. 120.

11 See s. 143 of Cap. 120

12 Tibatemwa-Ekirikubinza, L. (2005) *Offences Against the Person: Homicides and Non-fatal Assaults in Uganda* 128. Quoted in Centre for Reproductive Rights, above.

13 As above.

It states:

> 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.

Following the principles of statutory interpretation, the Penal Code should be interpreted in line with the Constitution. In this regard, it has also been noted that neither the Constitution nor the Penal Code provides an explicit legal definition of the term "unborn child" used in Article 22 of the Constitution, which is also used in the above mentioned sections 212 and 224 of the Penal Code Act.[14]

It has been posited that considering the text of section 212, article 22(2) should be interpreted liberally because the Penal Code deliberately treats as separate and distinct the following crimes:

- *Crime against a foetus*
- *Crime against a foetus about to be born*
- *Crime against a born child.*[15]

Accordingly, the Penal Code "takes great care to define the precise moments at which a child is no longer considered a foetus and is instead considered either an *unborn child* or a *born child* and thus a person capable of being killed."[16]

The fact that the law distinguishes between the crime of killing an "unborn child" and an offence under section 141 or 142 of the Penal Code, relating to procuring an abortion or miscarriage, may be interpreted to limit the scope of the constitutional provision to circumstances pertaining to the intentional death of an "unborn child."[17]

Nonetheless, section 224 above provides a window through which is may be legally possible to terminate a pregnancy, in good faith, in order to save the life of the mother. What emerges is that the Penal Code lacks clarity and contains a number of positions that can be interpreted in various ways.

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14 As above.

15 As above.

16 As above.

17 As above.

1.3 Case Law

There have not been many criminal cases in the courts on the above provisions in the Penal Code. From this, it may be inferred, firstly, that termination of pregnancy is usually carried out in secret, and secondly, that it is a crime in which there is often no complainant. Indeed, there are no *binding* Uganda Court judgments to which one can turn for legal precedents on abortion.

In a search by the Centre for Reproductive Rights, one case turned up in a magistrate's court, whose decisions are not binding. This was the case of *Uganda v. Dr. S. Nawabul Hassan and Sebakaki Kenneth*, in which a doctor was found guilty of attempting to procure an unlawful abortion under section 141. The woman in that case died from complications from the unsafe abortion.

It should be noted that the doctor in this case was the woman's boyfriend, though he did not perform the abortion himself. According to the judgment, the "unsafe abortion" was performed "at a clinic in Old Kampala."

The doctor was convicted under section 141 for procuring an abortion because (1) he "paid for the unlawful service" and (2) after the woman sought post-abortion care and did not improve, he "started administering drugs including IV fluids," which, according to the magistrate, "was also unlawful with a clear motive of terminating the pregnancy." The person who performed the unsafe abortion at the clinic in Old Kampala, who was also the owner of the clinic, was found guilty of manslaughter.[18]

Persuasive judgments from Kenya and England may nevertheless be helpful. In the Kenyan case of *Mehar Singh Bansel v. R,*[19] the court relied on *Rex v. Bourne*[20]. In the latter case, Justice MacNaughten noted that abortion was not unlawful if, in the opinion of the doctor, '*the probable consequence of continuance with the pregnancy will be to make the woman a physical or mental wreck.*'

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18 *Uganda v. Dr. S. Nawabul Hassan and Sebakaki Kenneth*, Chief Magistrate's Court – Kampala (2008, quoted in Centre for Reproductive Rights, above.

19 (1959) EA 813.

20 *Rex v. Bourne*, I Kings Bench 687 (1938).

This decision has been hailed as a landmark judgment in interpreting abortion laws in commonwealth countries, where decisions of the English Courts continue to have persuasive authority.[21]

A commentary on the ruling in Bourne states that it effectively created a mental and physical health exception to the criminalization of abortion and provided for access to legal abortion in cases of rape and being under-age. The judge's reasoning emphasized the girl's age and the "fact that she had been raped with great violence." The girl was under the age of fifteen.

The judge noted that *"[i]t is no doubt very undesirable that a young girl should be delivered of a child."* As support for this proposition, the judge relied on Parliament's legislative intent and medical testimony given at trial. He pointed to legislation prohibiting marriage for girls under 16 as evidence of Parliament's "view that a girl under the age of 16 ought not to marry and have a child."

He also pointed to medical evidence concerning girls' physical immaturity prior to the age of 18 as confirmation that "it must be injurious to a girl that she should go through the state of pregnancy and finally of labour when she is of tender years."[22]

This commentary is important for Uganda's advocacy efforts, as Uganda has a high teenage pregnancy rate (24% for girls in rural areas)[23] and a significant number of abortions occur among girls age below 18:

Article 31(1) of the Ugandan Constitution states that only men and women 18 years and above "have the right to marry and to found a family." Given this provision and the constitutional drafters' presumed legislative intent, combined with the continuing fact of girls' physical immaturity prior to the age of 18, it may be possible to argue for an exception to the criminalization of abortion for minors who become pregnant.[24]

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21 Centre for Reproductive Rights above.

22 As above.

23 GoU and UNICEF, *The National Strategy to end Child Marriage and Teenage Pregnancy 2014/2015 – 2019/2020* https://www.unicef.org/uganda/NATIONAL_STRATEGY_ON_CHILD_MARRIAGE-PRINT_READY.pdf Uganda's teen pregnancy rate is

24 Centre for Reproductive Rights, above.

Another Kenyan case, *Republic v John Nyamu & 2 others*[25] dealt with the question of whether fetuses were capable of being killed. The defendants were accused of murder. The evidence before the court was that they had disposed of bodies of stillborn babies. According to Judge K.H Rawal, for a child to become a person the most important ingredient was "when it had completely proceeded in a living state from the body of its mother". That ingredient was not present.[26] Accordingly, the fetuses in two counts were not persons capable of being killed and therefore there could be no conviction of murder.

25 Republic v. John Nyamu & 2 others [2005] KLRI

26 Ibid.

1.4 Administrative Guidelines

It is notable that Ministry of Health has made efforts to regulate abortion and guide physicians on the circumstances under which they may carry out abortions in accordance with the law. There have been several attempts at making guidelines.[27] Ministry of Health's 2006 *National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights* constitute the only government-issued document that clearly outlines the circumstances under which abortion may be provided in Uganda.

It is nonetheless a comprehensive document with potential to safeguard women and address many of the pitfalls in the current situation of lack of clarity on abortion laws.[28]

Under the Guidelines, abortion and post-abortion care are discussed under "comprehensive abortion care services." This type of service "is health care provided to a woman or a couple seeking advice and services either for terminating a pregnancy or managing complications arising from an abortion."

The circumstances under which safe abortion services should be made available under the guidelines include cases of:

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

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27 Besides the operational 2006 Guidelines, there were Ministry of Health guidelines of 2012 followed by an attempt to improve them under the 2015 Guidelines which were withdrawn.

28 The Centre for Reproductive Rights has observed that "very few copies appear to be in circulation, and the Ministry of Health itself no longer has copies for distribution. As a result, few health care providers seem to know about or possess a copy of these guidelines, leaving them unfamiliar with the permitted grounds for providing safe and legal abortions listed in this government-issued policy document." See Centre for Reproductive Rights (2012) *A Technical Guide to Understanding the Legal and Policy Framework on Termination of Pregnancy in Uganda,* https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/crr_UgandaBriefingPaper_v5.pdf

Under the guidelines, a medically induced abortion can be performed in a general hospital, referral hospital, or a Health Centre IV (HC IV) facility by a midwife, nurse, clinical officer, medical officer, or gynecologist/surgeon; a surgically induced abortion can be performed only in a general or referral hospital and must be done by a gynecologist/surgeon.

According to one gynecologist who helped draft the guidelines, “gynecologist/surgeon” means simply a gynecologist who has training in surgery – something all qualified gynecologists in Uganda have as part of their studies. They define “medically induced” as an abortion induced with the use of drugs, such as misoprostol. Surgically induced indicates an abortion performed through the use of an MVA or D&C procedure, or any type of surgical intervention.

The guidelines define post-abortion care as health care given to a woman who has had an abortion of any cause. The care, to be provided on a 24-hour basis, is to be an integral part of sexual and reproductive health (SRH) services. The services are to be provided in all health facilities equipped to handle the service. These facilities should observe the patients’ rights. Evacuation for incomplete abortion can be done in a Health Centre II-III facility, HC IV facility, general hospital, or referral hospital. Further, midwives, nurses, clinical officers, medical officers, and gynecologists may all offer evacuation for incomplete abortion and post-abortion family planning services.

The priority groups for post-abortion care under the guidelines are: adolescents; women with repeated abortions who need contraception; and women with repeated abortions who desire to have babies.

The guidelines address consent for post-abortion care services for children, emphasizing that written or appropriate consent should be obtained from the patient or legal guardian for evacuation for incomplete abortion and examination under general anesthesia, and any surgical interventions. It is notable that for a patient whose physical condition does not enable her to give a written consent, the procedure should be performed to save life.

In addition, the guidelines address sexual and gender-based violence service standards. They permit midwives, nurses, clinical officers, medical officers, and gynecologists/surgeons to offer termination of pregnancy services in cases where the pregnancy results from rape, incest, or defilement. In this context, the guidelines do not distinguish between medically induced and surgically induced abortions, permitting these same health care providers to offer surgical interventions.

Thus the guidelines are detailed, comprehensive, and clearly create a space within which legal abortions may be conducted in Uganda. Unfortunately, they are not well publicized or well-known and therefore their effectiveness may be limited.[29]

The Guidelines are supplemented by the *Ministry of Health's 2007 Handbook Management of Sexual and Gender Based Violence Survivors*. This is a national, standardized curriculum designed for use in pre-service and in-service training for nurses, midwives, clinical officers, medical officers, and other health professional trainees in the management of survivors of sexual and gender-based violence.

The handbook states that rape survivors:

> "*have a right to receive good quality health services, including reproductive health care, management of the physical and psychological consequences of the abuse, including prevention and management of pregnancy*."[30]

Thus, termination of pregnancy is a suggested option for rape survivors.

Another important document is the 2009 Ministry of Health Patients' Charter. The Charter invokes objective XX of the Constitution of Uganda, which provides that the state "*shall take all practical measures to ensure the provision of basic medical services to the population*," and frames the Charter as part of an effort to "progressively realize the right to Health."

The introduction states that "*this charter provides a basis for a legal and regulatory framework in health that contributes to improved capacity for quality health care*." It provides extensively for patient rights to medical treatment and care, the right to privacy, and the right to informed consent. This includes information on circumstances under which termination of pregnancy is allowed, in line with the afore-mentioned guidelines.

29 Centre for Reproductive Rights (2012).

30 Quoted in Centre for Reproductive Rights, above.

1.5 Observations on the current legal provisions

In summary, the current position of the law in Uganda is as follows:

- Sections 141-143 prohibit abortion when it is “unlawfully” procured.
- Section 224 can be read as permitting abortion for therapeutic reasons (mental and physical health).
- The Constitution does not speak directly to abortion, but regulates abortion by inference. Article 22(2) protects foetal life but also recognises the constitutionality of a law that permits abortion. This may be interpreted to mean that it recognises foetal life as a constitutionally protected interest while also giving constitutional legitimacy to legislative instruments and common law that permit abortion. [31]
- Persuasive precedents from Common Law Countries reveal that abortion is allowed in certain circumstances and that further, a fetus is not a “person” capable of being murdered.
- The Constitution contains a number of progressive provisions that may be leveraged to advocate for abortion law reform.
- Ministry of Health Guidelines represent a fairly comprehensive attempt by the government to regulate the manner and circumstances in which abortion may be allowed. They present an opportunity for increasing access to safe abortion if implemented.

The Centre for Reproductive Rights view on the current status of abortion law in Uganda is that *“Uganda’s laws and policies are more expansive than most believe, and the current legal and policy framework offers ample opportunities for increasing access to safe abortion services.”*[32]

31 See Ngwena, C. (2014*). Human Rights and African Abortion Laws: A handbook for Judges*, http://www.safeabortionwomensright.org/wp-content/uploads/2016/04/NgwenaAlliance2014-pdf.compressed.pdf

32 Centre for Reproductive Rights 2012, above.

In support of this, they were able to locate an official government provision written some years ago that supports abortion in certain circumstances. They quote the Permanent Secretary from the Ministry of Health saying:

I have to inform you that in this country abortion is acceptable for health and medical reasons and it is done only to save the life of the mother when it is threatened by the continuing pregnancy.[33]

Further the Solicitor General in a 2002 memo written for the Director General of Health Services in the Ministry of Health. In the memo, the Solicitor General stated that *Rex v. Bourne* "introduced the common law health exception to the law against abortion" and explained that "in Uganda abortions for health reasons are carried out on the basis of the English Common Law."[34]

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33 *Letter from Dr. S.L.D. Muyanga for the Permanent Secretary, Ministry of Health, to Dr. K.G. Mather, Chief Executive Officer,* Medical Section (Oct. 18, 1976), quoted in Centre for Reproductive Rights, above. In a questionnaire attached to the letter, the Permanent Secretary clearly marked life, physical health, and mental health as distinct legal grounds for abortion in Uganda.

34 As above.

2. RATIONALE AND JUSTIFICATION FOR REFORMING ABORTION LAW IN UGANDA

2.1 Public health and human well-being: The human and economic costs of abortion

There are a number of reasons why it is important to have a law on abortion. Abortions are one of the leading causes of maternal morbidity and mortality.[35] In 2013, an estimated 128,682 women were treated for abortion complications and an estimated 314,304 abortions were induced, up from 110,000 and 294,000 in 2003, respectively. The national abortion rate is 39 abortions per 1,000 women aged 15-49. [36]

Uganda has a high maternal mortality rate of 336 per 100,000 live births. The direct causes of death include haemorrhage (42%), labour (22%) and unsafe abortion (11%). The indirect causes of death are malaria (36%), anaemia (11%) and HIV/AIDS (7%).[37]

Studies elsewhere have shown that legalising abortion can significantly reduce maternal mortality. A study by Benson et al showed declines in abortion-related mortality in Romania, South Africa and Bangladesh. In all three countries, abortion policy liberalization was followed by implementation of safe abortion services and other reproductive health interventions. South Africa and Bangladesh trained mid-level providers to offer safe abortion and menstrual regulation services, respectively, Romania improved contraceptive policies and services, and Bangladesh made advances in emergency obstetric care and family planning.[38]

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35 Prada, E.,et al. (2016). Incidence of Induced Abortion in Uganda, 2013: New Estimates Since 2003. *PloS one*, *11*(11), November 1, 2016, http://dx.doi.org/10.1371/journal.pone.0165812

36 Ibid

37 MoH (2017), *Uganda Registers Decline in Infant and Maternal Mortality Rates*, http://health.go.ug/content/uganda-registers-decline-infant-and-maternal-mortality-rates See also: *Ending Preventable Child and Maternal Deaths: a promise renewed*; at http://www.apromiserenewed.org/countries/uganda/

38 Benson et al. (2011) Reductions in abortion-related mortality following policy reform: evidence from Romania, South Africa and Bangladesh. *Reproductive Health* 8:39, http://www.reproductive-health-journal.com/content/8/1/39

The other human cost that is often not discussed concerns the number of unwanted children. Whereas high maternal mortality rates are a good basis from which to argue for abortion, other possible arguments include the high rates of child abandonment, neglect and abuse in Uganda.[39] This includes a very high defilement rate of up to 10,000 children per year.[40] Some of these end in pregnancy and such girls should be allowed to abort safely.

A study in Prague, Czechoslovakia, confirmed that being born unwanted carries a risk of negative psychosocial development and poor mental health in adulthood. Unwanted pregnancy subjects, especially only children (no siblings) became psychiatric patients (especially in-patients) more frequently than the accepted pregnancy controls and also more often than their siblings.[41]

Anti-abortion campaigners often say that many women grow to love their children even if they were initially unwanted. However, there is anecdotal evidence of just as many or even more children who went on to suffer abuse and neglect because they were unwanted.[42]The stories of child abuse in Uganda's media outlets are quotidian and often quite gruesome,[43] and can provide a basis for argument.

Moreover, the Uganda Demographic and Health Survey (UDHS)shows that on average, Uganda women have two more children than desired,[44] further showing the gap between wishes and reality.

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39 Rumanzi, P (2012) "40 babies dumped in Ntungamo," http://www.monitor.co.ug/News/National/40-babies-dumped-in-Ntungamo/-/688334/1458018/-/97x-ukg/-/index.html

40 Uganda Police Crime Report 2014.

41 David, HP, "Born unwanted, 35 years later: the Prague study."*Reproductive Health Matters* 2006 May; 4(27):181-90.

42 Beisner, L (2012) "I wish my mother had aborted me," *The Guardian*, Wednesday 15 August 2012, (https://www.theguardian.com/commentisfree/2012/aug/15/i-wish-my-mother-aborted-me

43 See for example, "Uganda: The cry of abused and neglected children," retrieved from https://spookynewsug.wordpress.com/2012/11/26/uganda-the-cry-of-the-abused-and-neglected-child/

44 UDHS 2011, Chapter 9 on Reproductive Health.

Unsafe abortions are costing the country a significant amount of money, and legalizing what is already a frequent occurrence could save a lot of money that could be invested into the system to fund other important aspects of the poorly funded health system and infrastructure. It is estimated that one in five pregnancies result in an abortion, resulting in an estimated 297,000 induced abortions annually.

Of these, at least 85,000 result in complications necessitating treatment. Babigumira et al., using a decision-analytic model to represent the consequences of an induced abortion, estimated an annual per-patient societal cost of $171, translating into $64 million in costs per year for the country. In an empirical analysis, it was found that the annual cost of treating abortion complications was approximately $131 per case and $13.9 million per year in Uganda, and an estimated $20.8 million per year that would be needed to satisfy all demand for management of abortion complications in the country. [45]

Furthermore, statistics show a positive relationship between poverty, women's education and teenage pregnancy with girls from the poorest households and no education having higher rates of pregnancy (34% and 45% respectively) compared to those from the wealthiest households and with secondary education (16% and 16% respectively).

Child marriage and adolescent pregnancies are linked to significant negative consequences on girl's physical and psychological wellbeing; and general development of girls including their education opportunities and outcomes. Evidence shows that in spite of Government's support and implementation of Universal Primary Education (UPE) and Universal Secondary Education (USE) which has expanded access to education for Ugandans, many girls are increasingly dropping out of school.

The completion rates both at primary and secondary level remain behind those of the boys estimated at 66% and 24% compared to the boys – 68% and 52% respectively.

Progression to secondary school education is more limited for girls (46.6%) than the boys (53.4%) Child marriage and teenage pregnancies are among the major causes of school dropout.

45 Lubinga, S. J., G. A. Levine, et al. (2013). "Health-related quality of life and social support among women treated for abortion complications in western Uganda." Health and Quality of Life Outcomes11(1): 118.

Low primary level completion rates and the very low progression to post-primary education imply that a large number of girls leave school with limited ability to be productive in the labour market and thus their economic capabilities and employment opportunities and/or options are limited. [46]

Marrying and having children at young ages causes lifelong poverty and retards a country's economic and human resource progress. In fact, child marriage is both a cause and a consequence of poverty and gender inequality.[47]

46 GoU & UNCEF (2015), Uganda National Strategy to end Child Marriage and Teenage Pregnancy, https://www.unicef.org/uganda/NATIONAL_STRATEGY_ON_CHILD_MARRIAGE-PRINT_READY.pdf

47 As above.

2.2 Compliance with Human Rights and Gender Equality International Law Obligations

The Uganda Constitution emphasises "respect for international law and treaty obligations," and treaties that have been ratified but not yet domesticated are considered persuasive authorities by Ugandan Courts. Some decisions by the Constitutional Court refer to international human rights treaties to which Uganda is a party, stating that decisions of treaty-monitoring bodies are "very persuasive in our jurisdiction."

Courts have also stated that the Court "ought to interpret our law so as not to be in conflict with the international obligations that Uganda assumed when it acceded to a human rights treaty;" and that "where the words of the Constitution or other law are ambiguous or unclear or are capable of several meanings," the Court may look to "international instruments to which this court has acceded and thus elected to be judged in the community of nations."[48]

The international law framework provides a progressive basis on which to launch domestic law reform efforts. African Union has paved the way for decriminalization through the Maputo Protocol to the African Charter on the Rights of Women. This Protocol was largely an initiative of civil society, backed by the African Commission on Human and Peoples' Rights.[49]

The Protocol provides in Article 14(2) (c) that *states parties shall take all appropriate measure to protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.*

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48 See Constitution, objective XXVIII(i)(b) (1995). See also judgment in *Attorney General v. Susan Kigula & 417 Ors* Constitutional Appeal No. 03 of 2006, ILDC 1260, cited in Interights, Selected International Standards and Case-Law: Litigation Surgery on the Right to Education in Africa 64 (Mar. 12–15, 2012). See further, *Tinyefuza v. Attorney General,* Constitutional Petition 1 of 1996 (unreported). Quoted in Centre for Reproductive Rights (2012), above.

49 See commentary on the Protocol and its abortion provisions by Ngwena, C. (2010) Inscribing Abortion as a Human Right: Significance of the Protocol on the Rights of Women in Africa. Human Rights Quarterly 32 (4): 783-864

It is notable that Uganda has filed a reservation on Article 14(2) above, as follows:

> Article 14(2)(c) interpreted in a way conferring an individual right to abortion or mandating State party to provide access thereto. The State is not bound by this clause unless permitted by domestic legislation expressly providing for abortion. The Republic of Uganda makes this ratification on the understanding that the above clause of the present Protocol shall not apply to the Republic of Uganda.[50]

Commenting on this reservation, the Centre for Reproductive Rights has noted:

> This reservation simply declares the government's unwillingness to be bound by this particular clause in the Maputo Protocol. *However, it has no effect on existing legislation, does not create new legislation, and does not preclude future development of legislation to increase access to safe and legal abortion in Uganda.*[51]

In any case, there are soft law provisions that may be invoked in the law reform advocacy process.[52] These include favorable decisions of UN Human Rights Treaty Monitoring Bodies, such as the Human Rights Committee, which has settled that abortion must be allowed in certain cases to save the life of the mother or baby.

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50 Ministry of Foreign Affairs, AOG 238/01, Instrument of Ratification Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (July 21, 2010)

51 Centre for Reproductive Rights (2012). *A Technical Guide to Understanding the Legal and Policy Framework on Termination of Pregnancy in Uganda.* https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/crr_UgandaBriefingPaper_v5.pdf

52 Ngwena C. (2014) Using human rights to realize access to safe, legal abortion in Uganda:The state's obligation to implement national abortion law, CEHURD Discussion Paper No. 1

The Committee has held that the failure by a Peruvian hospital to grant an abortion to a 17 year old girl, who was carrying a fetus afflicted with anencephaly, resulting in the birth of a severely deformed child who she was nonetheless forced to breastfeed for four days until the baby died, was a violation of article 7 of the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) (freedom from cruel, inhuman and degrading treatment).[53]

Even without an express right to abortion, it is possible to invoke other human rights to support advocacy efforts in abortion law reform. These include the rights to equality, human dignity, life, integrity and security of the person, and health.[54] In Uganda, article 33 of the Constitution should be leveraged. It provides that:

> Women shall be accorded full and equal dignity of the person with men. The State shall provide the facilities and opportunities necessary to enhance the welfare of women to enable them to realise their full potential and advancement. The State shall protect women and their rights, taking into account their *unique status and natural maternal* functions in society. Women shall have the right to equal treatment with men and that right shall include equal opportunities in political, economic and social activities.
>
> Without prejudice to article 32 of this Constitution, women shall have the right to affirmative action for the purpose of redressing the imbalances created by history, tradition or custom. Laws, cultures, customs or traditions which are against the dignity, welfare or interest of women or which undermine their status, are prohibited by this Constitution.

As mentioned above, only women can get pregnant, and therefore ensuring access to safe abortion in order to preserve their physical and mental health, if endangered, is one of the way of recognising their unique status and maternal functions.

53 KL v Peru. Quoted in "Using Human Rights to realise access to safe, legal abortion in Uganda," CEHURD Discussion Series No. 1 of 2014.

54 See Ngwena (2010) above.

Moreover, it should be borne in mind that due to the prevalence of gender discrimination and sexual and gender-based violence in Uganda, few women are in a position to exercise freedom of choice regarding when to have sex, with whom and whether or not to use birth control when they do. According to the Uganda Demographic and Health Survey, the proportion of ever-partnered women aged 15-49 years experiencing intimate partner physical and/or sexual violence at least once in their lifetime is 51%.[55] The defilement rate of 9,598 cases per year should also be borne in mind.[56]

55 UBOS, UDHS 2011 at http://www.ubos.org/onlinefiles/uploads/ubos/UDHS/UDHS2011.pdf

56 Uganda Police Force (2013) Annual Crime, traffic and Road Safety Report, http://www.upf.go.ug/download/publications(2)/Annual_Crime_and_Traffic_Road_Safety_Report_2013(2).pdf

3. OPTIONS FOR LAW REFORM: EXPERIENCES FROM OTHER AFRICAN COUNTRIES

3.1 Overview of the situation of Abortion law in Africa

According to the Centre for Reproductive Rights, the following countries in Africa have eased legal restrictions on abortion over the past years:[57]

Year	Country	Previous Position	Current Position
1996	Burkina Faso	prohibited without any explicit exceptions.	Permitted to save a woman's life and to protect her health, as well as in cases of rape, incest, or fetal impairment.
	South Africa	Permitted abortion only to save a woman's life, preserve her physical or mental health, or in cases of rape, incest, or fetal impairment.	Legalised without restriction as to reason during the first 12 weeks of pregnancy, and thereafter on numerous grounds.
2000	Guinea	Previously, abortion was permitted only to save a woman's life and to protect her health.	Guinea permits abortion to save a woman's life and to protect her health, as well as in cases of rape, incest, or fetal impairment.
2002	Chad	Considered legal only to save a woman's life.	Abortion is legalized in Chad to save a woman's life and to protect her health, as well as in cases of fetal impairment.
2003	Benin	Abortion was considered legal only to save a woman's life.	Benin permits abortion to protect a woman's life and health and in cases of rape, incest, or fetal impairment.

57 Centre for Reproductive Rights (2014) *Abortion Worldwide: 20 Years of Reform*, Briefing Paper, at https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/20Years_Reform_Report.pdf

2004	Ethiopia	Only permitted abortion to preserve a woman's life or health.	Ethiopia amended its penal code to permit abortion to preserve a woman's life or health and in instances of rape, incest, fetal impairment, as well as where the woman is a minor, or when she has a physical or mental injury or disability.
2005	Swaziland	Abortion was permitted under common law to save the pregnant woman's life with no clearly defined exceptions.	Swaziland enacted a new constitution that authorized abortion to save a woman's life or to protect her physical or mental health, and in cases of rape, incest, fetal impairment, or "unlawful sexual intercourse" with a woman with a mental disability.
2006	Niger	Prohibited without any explicit exceptions.	Abortion is permitted in Niger to save a woman's life and health and in cases of fetal impairment.
2007	Togo	Although the penal code made no explicit mention of abortion, the procedure was considered illegal in most or all circumstances.	Abortion is legalized in Togo to save a woman's life and to protect her health, as well as in cases of rape, incest, or fetal impairment.
2010	Kenya	Previously, abortion was only permitted to save a woman's life.	Kenya adopted a new constitution that explicitly permits abortion to save a woman's life or health or where emergency treatment is needed.

2012	Lesotho	Abortion was banned. The position was like Swaziland's without any explicit exceptions.	Lesotho currently permits abortion where pregnancy poses a risk to the woman's life or health and in instances of rape, incest and fetal impairment.
	Mauritius	The position was like Swaziland's. Abortion was banned without any explicit exceptions.	Mauritius amended its abortion law to authorize abortion where the pregnancy poses a risk to the woman's life or her physical or mental health, in instances of fetal impairment, and where pregnancy results from rape.
	Rwanda	Abortion was only permitted to preserve the health of the woman.	Permitted when a woman becomes pregnant as a result of rape, incest or forced marriage or if the continuation of the pregnancy jeopardizes the health of the woman or the fetus.
	Somalia	Abortion was prohibited without any explicit exceptions.	Enacted a new constitution that authorizes abortion to save the life of the woman.
2014	Mozambique	Previous law was restrictive and punitive	Following changes to the penal code, a woman can get legal abortion on request during the first 12 weeks of pregnancy. In cases of rape or incest, abortions can be legal during the first 16 weeks, and in cases of fetal anomaly, the first 24 weeks. Abortions must be performed at officially designated facilities by qualified practitioners.

In summary, the current position in African countries can be summarised as follows:[58]

Current position in African countries

Restricted to saving the woman's life	Angola, Central African Rep., Congo (Brazzaville), Cote d'Ivoire, D.R. Congo, Gabon, Guinea-Bissau, Madagascar, Malawi, Mali, Mauritania, Mauritius, Nigeria, Sao Tome & Principe, Malawi, Mali, Mauritania, Mauritius, Nigeria, Sao Tome & Principe, Senegal, Sudan, Somalia, Tanzania, Uganda
Physical health (as one of the grounds for abortion)	Benin, Burkina Faso, Burundi, Cameroon, Chad, Comoros, Djibouti, Equatorial Guinea Eritrea, Ethiopia, Guinea, Lesotho, Niger, Rwanda, Togo, Zimbabwe
Physical and mental health (as part of the grounds for abortion)	Botswana, Gambia, Ghana, Liberia, Namibia, Seychelles, Sierra Leone, Swaziland
Physical and mental health, and socioeconomic grounds (as some of the grounds for abortion)	Zambia
No restrictions as to reasons	Mozambique, South Africa and Cape Verde

There are various options for reforming abortion law. It has been proposed that *abortion should be treated as an issue of health and welfare as opposed to one of crime and punishment*.[59] Decriminalizing abortion and reforming the law can include the following options:

- Clarifying the existing law; for instance, removing confusing terminologies in Uganda's current penal code that make distinctions between ending the life of an unborn child, procuring a miscarriage, etc. Harmonising all existing laws, including the Common Law position and administrative guidelines to minimise contradictions and inconsistencies.

58 This classification is adapted from Boland, R., & Katzive, L. (2008). Developments in laws on induced abortion: 1998-2007. *International Family Planning Perspectives*, 110-120.

59 Cook, R. J., & Dickens, B. M. (1981). Abortion laws in African Commonwealth countries. *Journal of African Law*, *25*(02), 60-79.

- Liberalizing existing law to allow abortion based upon certain indications, such as physical and mental health or socio-economic circumstances.
- Limiting/removing women's criminal liability for seeking an abortion.
- Allowing hindsight contraception.
- Protecting providers treating women in good faith, as implied in Section 224 of the Penal Code Act.
- Protecting providers who treat women with incomplete abortion as part of providing emergency and life-saving treatment.
- Punishing providers who fail to provide care to women in need, *with the exception of those seeking protection under a conscience clause*.[60]

The arguments to be relied on to justify law reform can be summarised as follows:

Arguments from Public health:

- Unsafe abortion is a major contributor to maternal deaths.
- Young and poor women suffer most from unsafe abortion, but all women are at risk.
- Restrictive abortion laws do not prevent abortion but only push it underground, increasing risks to women.
- Caring for women with complications of unsafe abortion costs the economy a lot and places a tremendous burden on the health system. Treating abortion complications costs more than providing safe abortion.
- The unmet need for contraception among married couples in is very high, making high rates of unwanted pregnancy inevitable.

Arguments from human rights

- Individuals, including women, have the right to make their own decisions regarding when and whether to have children and to have access to information on reproductive health.
- Individuals, including women, have the right to physical security, bodily integrity, privacy, liberty, equality and freedom from discrimination.
- Uganda has ratified and therefore is bound to these and other principles and commitments set forth in international agreements such as CEDAW and ICPD Programme of Action.

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60 As above

3.2 Law reform options

In accordance with the experiences of other African as explained above, the options for Uganda may include:

1) Amend the Penal Code to clarify the current position and eliminate confusing distinctions between “ending the life of an unborn child,” “procuring a miscarriage,” etc. and bring it line with the Ministry of Health Guidelines on Reproductive Health Services, which allow abortion on grounds of physical and mental health including in cases where pregnancy is a result of non-consensual sex or defilement.

2) Decriminalize and allow abortion with no restrictions as to reasons. This is regarded as the best option to safeguard women’s right to dignity and equality. However, this option in unlikely to succeed in Uganda due to factors discussed in the subsequent section.

3) Enact a specific law on the termination of pregnancy specifying not just the reasons for which a pregnancy may be terminated, but also the means by which health services involving pregnancy termination may be delivered. This should cover:
   - Clarification of the qualifications of practitioners who may treat women;
   - Specification of the facilities that may treat women, perhaps broken down by gestational duration of the pregnancy;
   - Specifying gestational limits during which the procedure can be performed;
   - Clarifying approval procedures and consents;
   - Allowing for conscientious objections to performing the procedure.

CEHURD has discussed the above options with stakeholders and proposals have been made. It is noteworthy that many of the proposals are substantively covered in the Ministry of Health guidelines on Reproductive Health. Therefore, it is critical to understand the extent to which the guidelines are known amongst health professionals, amongst the public, and how they are being implemented. This may provide pointers on the way forward.

4. LESSONS LEARNED FROM OTHER AFRICAN COUNTRIES' LAW REFORM EFFORTS

4.1 Need for a broad based coalition

Apart from Ethiopia, lessons learned have not been well documented. Ethiopia credits its success in abortion law reform to a broad-based coalition of civil-society and other actors in favor of liberalizing abortion restrictions, the Abortion Advocacy Working Group. It comprised representatives of the medical and legal professions and nongovernmental organizations (NGOs) involved in promoting women's health and rights, gender equity, family planning and reproductive health, as well as the National Office of Population.

Coalition members agreed on a structure and process for working together, as well as roles and responsibilities. By consensus of the entire group, IPAS Ethiopia assumed the role of coalition leader, with responsibility for calling meetings, preparing and distributing minutes, and coordinating members' activities. Coalition members agreed on the following core strategies to promote liberalization of the law on abortion:

- Building public opinion
- Shifting policymakers' perspectives
- Creating an enabling environment for service providers

4.2 Strategic targeting of interest groups

In Ethiopia, reformists organized workshops targeting different audiences (including opinion leaders and the media) with information and perspectives on unsafe abortion, suggest policy alternatives and promote debate of related issues. In Uganda, a key interest group to target could be the religious leaders, and lessons can be borrowed from on-going efforts to reform the domestic relations laws. For instance, Action Aid has facilitated the Domestic Bill Coalition to engage in dialogue with religious groups, which enabled them to reach consensus on the minimum positions that should be included in the bill.[61]

4.3 Media Strategies

CEHURD has already determined wide coverage of reproductive health issues in the media and hence a favourable climate for coverage of such issues in the media. The existing media strategies can also include the following as was the case in Ethiopia:

- Submitting articles about the impact of unsafe abortion to newspapers;
- Writing letters to the editor;
- Participating in radio panel discussions;
- One-on-one meetings with parliamentarians, regional lawmakers and other influential people to discuss and provide evidence of the health and cost impact of unsafe abortion;
- Targeted advocacy with professional associations, regional health bureaus, medical and nursing schools and NGOs;
- Enlisting local women's associations and other groups to organize public rallies and discussion forums in different parts of the country;
- Supporting local organizations' public-education efforts, such as radio programs and production of informational materials.[62]

Personal stories of individual women's experiences with unwanted pregnancy and unsafe abortion, to engage listeners on an emotional level were found to be helpful in Ethiopia.

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61 http://www.actionaid.org/uganda/2015/05/marriage-and-divorce-bill-coalition-minimum-position

62 IPAS, (2008) Tools for progressive policy change Lessons learned from Ethiopia's abortion law reform, www.ipas.org/~/media/Files/Ipas%20Publications/ETHPOLE08.ashx

4.4 Preparing for Opposition

One of the counter-intuitive strategies used by Ethiopian reformists was not to endorse a specific proposal for decriminalization or liberalization of the law. This was partly due to different ideas among the group about the ideal content of a new law, but also because members believed that specifying conditions in which abortion should be permitted could actually limit the ultimate result.

The most significant opposition in Ethiopia came from religious groups, especially religious health workers. It was suspected they were funded and supported by US right wing groups. The influence of these in reproductive rights discourses has been researched.[63]

The church, especially the Roman Catholic has restrictive views on family planning. The Catholic Church believes that artificial contraception is sinful and immoral and may frustrate a divine plan to bring a new life into the world. Instead of using birth control methods such as the pill, IUDs, diaphragms, and condoms, Catholics can use Natural Family Planning techniques.[64]

A discourse analysis of newspaper articles in Uganda showed that the Catholic Church has a strong position within the Ugandan society and their stance on abortion tends to have great influence on the way other actors and their activities are presented within the media, as well as how stakeholders choose to convey their message, or choose not to publicly debate the issue in question at all. It is important that the advocacy effort should emphasise public health, human rights and gender equality and steer debate away from religious discourses on the sanctity of life.[65]

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63 Kaoma, Kapya (2009) *Globalising the culture wars: U.S: Conservatives, African Churches and Homophobia*, http://www.politicalresearch.org/2009/12/01/globalizing-the-culture-wars-u-s-conservatives-african-churches-homophobia/#sthash.a9pbBV3s.dpbs

64 *The Catholic Church and Contraception - dummies. Retrieved from-* www.dummies.com/religion/.../catholicism/the-catholic-church-and-contraception/

65 Larsson, S., Eliasson, M., Allvin, M. K., Faxelid, E., Atuyambe, L., & Fritzell, S. (2015). The discourses on induced abortion in Ugandan daily newspapers: a discourse analysis. *Reproductive health*, *12*(1), 58.

In Malawi, Churches opposed the Termination of Pregnancy Bill that would have allowed abortion to preserve physical and mental health; and in cases of rape, incest, defilement; or where the foetus is severely malformed.[66] The Bill has now been shelved. This shows the need for adequate preparation.

Although religion poses a substantial threat, it has been observed by some religious commentators that at the heart of church teachings on moral matters is a deep regard for an individual's conscience. A commentary by a Priest says that "a human being must always obey the certain judgment of his conscience," and that even in cases of a conflict with the moral teachings of the church, Catholics "not only may but must follow the dictates of conscience rather than the teachings of the Church."[67]

The Anglican Church, another likely vocal opponent, encourages its members to think through issues themselves in the light of the Christian faith and in dialogue with the Christian community. The Church of England combines strong opposition to abortion with a recognition that there can be - strictly limited - conditions under which it may be morally preferable to any available alternative.[68]

However, activists may decide to take the option of Ethiopian reformists which was not to engage in the religious debate and simply let it blow over.[69]

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66 Muheya, G. (2016) 'Malawi govt says there is no abortion bill as hundreds join 'March for Life' – Nyasa Times, at: http://www.nyasatimes.com/malawi-govt-says-no-abortion-bill-hundreds-join-march-life/#sthash.cdpU96Ci.dpuf

67 O'Brien John (2015) The Catholic Case for Abortion Rights, http://time.com/4045227/the-catholic-case-for-abortion-rights/ Time Magazine Sept 22 2015

68 Church of England. Abortion: A Briefing Paper, https://www.churchofengland.org/media/45673/abortion.pdf

69 IPAS, above.

4.5 What comes after law reform?

In Rwanda, the requirement for judicial consent before an abortion, combined with a requirement that it can only be performed by a doctor (self-induced abortion is a crime) has had a detrimental effect. When on health grounds, two doctors must also give written approval.

As result, the young and the poor end up in jail because most of the young girls had little knowledge about contraceptives and cannot afford lawyers when faced with charges for self-induced abortion. As a result, 24% of all women in jail were charged with illegal abortion. It is therefore important to ensure that the new law does not give with one hand and take with the other by putting in place unnecessarily restrictive consent provisions.

In South Africa, conscientious objection has continued to be a barrier to women accessing abortion even after it was legalised without restriction. In most public sector facilities there was a general lack of understanding concerning the circumstances in which health care providers were entitled to invoke their right to refuse to provide, or assist in abortion services. Providers seemed to have poor understandings of how conscientious objection was to be implemented, but were also constrained in that there were few guidelines or systems in place to guide them in the process.

South Africa's experience shows that "in order to disentangle what is resistance to abortion provision in general, and what is conscientious objection on religious or moral grounds, clear guidelines need to be provided including what measures need to be undertaken in order to lodge one's right to conscientious objection. This would facilitate long term contingency plans for overall abortion service provision."[70]

A study from Zambia showed that unsafe abortion continued even after the law was liberalised, due to lack of knowledge of the law and other factors such the lack of mid-level providers in the provision of medical abortion services continued limited access to contraception, especially for adolescents; and demands for unofficial provider payments.[71]

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70 Harries, J., Cooper, D., Strebel, A., & Colvin, C. J. (2014). Conscientious objection and its impact on abortion service provision in South Africa: a qualitative study. *Reproductive health*, *11*(1), 16. At https://reproductive-health-journal.biomedcentral.com/articles/10.1186/1742-4755-11-16

71 Leone, et al. (2016). The individual level cost of pregnancy termination in Zambia: a comparison of safe and unsafe abortion. *Health policy and planning*, *31*(7), 825-833.

Their experience shows that law reform is only a starting point and that other actions must be taken as well, such as dissemination of the law, expanding access to contraception, expanding access to health workers who can perform safe abortions and eliminating unofficial payments in the health system.

In Tunisia, women continued to be denied abortion even after it was legalised due to several factors such as gestational age, health conditions, and logistical barriers. Women were denied for gestational age were turned away for being too early and too far along in pregnancy. Some women reported being referred to other facilities because they were diabetic, had asthma, and had previously taken an anticoagulant medication for blood clotting. Women expressed confusion about why their health conditions were impacting their access to abortion care.

Several women were not explicitly denied care but instead told to wait long periods or to go home and return later for care. This was considered a denial of care because women were not able to get the care they wanted on that day and they reported it was unlikely that they would ever have successfully obtained an abortion at the given facility. Some women were made to wait for many hours. This shows that in addition to law reform, significant investment will need to be made in improving health worker to population ratio and availability of logistical facilities for the termination of pregnancy.[72]

72 Hajri, S., et al. (2015). 'This Is Real Misery': Experiences of women denied legal abortion in Tunisia. *PloS one*, *10*(12), e0145338.

5. CONCLUSION AND RECOMMENDATIONS

Previous experiences from other countries, particularly Ethiopia, show that the following factors can be critical to the success of law reform efforts:

- Lawmakers' keen awareness that religion should not influence governance. This is not easy in Uganda where the motto says "For God and my Country" but the fact that the Constitutions says that Uganda shall not adopt a State religion is important. [73] Therefore the debate should stick to public health and human rights discourse and not venture into religious arguments.
- A strong, active and well-organised civil society. Civil Society in Ethiopia further identified the following internal factors as critical:
  - A manageably sized coalition of dedicated advocates representing multiple sectors and perspectives;
  - Strong coalition leadership and a strong shared sense of ownership among coalition members;
  - Clearly defined strategies and roles for all members;
  - Use of consistent, yet multi-faceted messages, emphasizing both public health and human rights that appealed to multiple constituencies;
  - Participation of highly respected individuals from several relevant fields as outspoken, active champions of reform;
  - Personal relationships with parliamentarians, government officials and other influential individuals that led to important collaborations and opportunities for advocacy;
  - Advocates' reliance on a strong body of evidence on the detrimental health, social and economic impact of unsafe abortion in the local context.
- A medical community sensitized to problems related to unsafe abortion. Medical researchers in Uganda and elsewhere have amassed significant research documenting the incidence and impact of unsafe abortion. This should be synthesised and presented in a digestible format for legislators.

73 Article 7.

- Widespread recognition of the ineffectiveness of legal prohibition of abortion and of how common unsafe abortion and related problems are. The fact that there are no cases in the courts on abortion is instructive.

- Pre-existing governmental support for international human-rights conventions and other instruments upholding women's rights. In this regard, Article 33 of the Constitution which recognises women's status in society and their maternal role would be critical.

- Pre-existing governmental reproductive health and population policies, such as the Ministry of Health Guidelines and SGBV Manual. This are important as they reveal the pre-existing official position of the government in practice.

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