



THE STAKES ARE HIGH

THE TRAGIC IMPACT OF UNSAFE
ABORTION AND INADEQUATE
ACCESS TO CONTRACEPTION
IN UGANDA

CENTER
FOR
REPRODUCTIVE
RIGHTS

O'NEILL
INSTITUTE
FOR NATIONAL & GLOBAL HEALTH LAW
GEORGETOWN LAW

International Women's Human Rights Clinic
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The photographs used in this publication are for illustrative purposes only; they do not imply any particular attitudes, behaviours or actions on the part of any person who appears in them. None of the people pictured are clients of the Center.

FOREWORD AND INTRODUCTION

Foreword

It is tragic that women continue to lose their lives as a consequence of their ability to become pregnant. The fact that communities, societies, and nations around the globe can stand aside and watch as numerous young, energetic, and productive women perish through circumstances that are completely preventable is despicable.

In the current era, progress in knowledge and technology has led to advances that span economic, commercial, agricultural, and medical fields, to name just a few areas that have seen advances in human development. The exception to such progress is found in women’s access to reproductive health and rights.

It is only in issues related to reproductive health and rights, and particularly where only women are affected, that religious, moral, and cultural attitudes continue to prevent action to save women’s lives. Unfortunately, it is the very individuals and communities in society that are not ready to accept sexuality education for all, safe sex practices, and contraception, including emergency contraception—all scientifically known avenues to prevent unplanned and unintended sex and pregnancy—that at the same time are wholly opposed to medical help for women who suffer the consequences: unwanted pregnancies, leading to unsafe abortion, injury, and death.

Many studies have shown that women’s access to increased rights in making reproductive choices, including effective contraception and safe abortion services, leads to better health for women, more satisfactory reproductive health outcomes, and less morbidity and mortality related to unwanted pregnancy and unsafe abortion. The values, attitudes, and morals of societies worldwide—including in global South countries like Uganda—must change and make the woman and her well-being and health the centre of discussion. That is the only way we shall be able to strengthen and empower women and improve their reproductive health. Women’s national, regional, and international human rights must be recognized, and the resulting standards and policies must be enforced, to ensure women’s sexual and reproductive health. That is the only way forward. Bravo to the women of Uganda, Africa, and the world.

Dr. Charles Kiggundu
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Introduction

Approximately one in five pregnancies in Uganda ends in an induced abortion.¹ This is significant given the high incidence of unsafe abortions in the country. Unsafe abortion—the termination of a pregnancy either by unskilled persons or in an environment that does not meet the minimum medical standards, or both,²—increases women’s risk of abortion-related complications and death. In some instances, unsafe abortion occurs when women are forced to take matters into their own hands—self-administering substances or objects that result in either grave injuries or death.

Each year, an estimated 297,000 induced abortions occur in Uganda,³ with nearly 85,000 receiving treatment for complications of unsafe abortion.⁴ In addition, about 65,000 experience complications relating to unsafe abortion but do not receive any treatment.⁵ The government is yet to develop any official statistics on abortion or abortion-related complications but recognizes that unsafe abortion remains a leading cause of maternal injuries and death in the country—causing as much as 26% of maternal deaths.⁶

In 2012, the Center for Reproductive Rights developed *A Technical Guide to Understanding the Legal and Policy Framework on Termination of Pregnancy in Uganda*.⁷ The objective of the *Technical Guide* was to “clearly and comprehensively lay out the laws and policies governing termination of pregnancy in Uganda so that discussions of the law and law reform are based on a common understanding of the existing legal and policy framework.”⁸ **A key finding was that Uganda’s abortion laws and policies are unclear, confusing, and contradictory but they are more expansive than most believe.⁹ However, the limited interpretations of the legal framework by the courts and other government bodies, and the extremely restricted access to relevant information, have resulted in lack of comprehensive information about the law among women, health care providers, law enforcement, the judiciary, and regulators, among others.¹⁰** The *Technical Guide* identifies as one example of limited access to information the difficulty in obtaining a copy of the Ministry of Health’s 2006 National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights (Reproductive Health Guidelines). This document (now revised) is “the only government-issued document that clearly outlines the

INTRODUCTION

circumstances under which abortion may be provided in Uganda.”¹¹ Yet few healthcare providers have access to or have even seen it.

The stories documented in this report support the key findings of the *Technical Guide* and highlight the consequences of the Ugandan government's failure to ensure comprehensive access to family planning and safe abortion services under the law. Each testimonial puts a human face on the statistics of unsafe abortion identified above, and exemplifies the obstacles women face in accessing both safe and legal abortion and family planning information and services—with tragic consequences.

Indeed, as many of the stories show, there is a persistent and widespread perception that abortion is completely criminalized except when done to save a woman's life. Yet, as discussed in the *Technical Guide*, the Ugandan legal framework permits abortion on mental and physical health grounds as well.¹² This understanding of the law is echoed in the National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights (2006 and as revised), which were developed to implement the law and which enumerate a number of health grounds on which safe abortion services should be provided.¹³ **These grounds include severe maternal illness threatening the health of a pregnant woman, cancer of the cervix, and women living with HIV who request termination.**¹⁴ **The Reproductive Health Guidelines also identify cases of sexual violence such as rape, incest, and defilement, as grounds for providing abortion services.**¹⁵

Nonetheless, the perceived illegality of abortion services has led to stigma, fear, and secrecy which have driven the practice of termination of pregnancy underground, forcing women to take desperate measures, with deadly consequences. Many of these women may meet the criteria for access to legal abortion under the law. However, skilled providers are either unaware of the content of the Reproductive Health Guidelines, or are reluctant to provide the comprehensive services outlined in them for fear of criminal prosecution. As a result, they refuse to provide safe services when approached and ultimately end up providing the same women with post-abortion care (PAC) services after they are already experiencing life-threatening complications from unsafe abortions.¹⁶ Even worse, they may have to watch them die.¹⁷

While some women are able to secure safe services from a very limited number of skilled providers if they can locate them and can afford the substantial cost, many have no option but to rely on unsafe abortion services. In particular, low-

income women and women who live in rural areas are more likely to have unsafe abortions and face greater risks of injuries and death.¹⁸ Adolescent girls are also less likely to be able to access and afford safe abortion services and may feel additional pressure to terminate a pregnancy because of the social stigma of pregnancy and the difficulties of continuing their education. Although health care facilities—particularly the public hospitals, which treat the most severe abortion-related complications—have a duty to provide PAC services to women, providers in these health facilities are frequently hostile and biased and delay providing care to women seeking PAC due to pervasive abortion-related stigma. This places women at increased risk of long-term disabilities or death.

Compounding the situation, lack of access to comprehensive and accurate family planning information and services has led to a significantly high level of unplanned pregnancies, many of which also end in unsafe abortions. The reasons for lack of access stem from the government's failures to ensure the availability and accessibility of a wide range of contraceptives, reduce or eliminate stock-outs, and tackle the widespread myths and misconceptions associated with contraceptive use. The government has also failed to eliminate barriers posed by sociocultural standards that construe women as subordinate to men and result in discrimination against women. An example of this type of barrier is the practice of requiring spousal consent; this consent requirement is wrongly and strictly imposed by some health facilities even though the Reproductive Health Guidelines explicitly state it is not required for family planning services. This practice violates women's fundamental human rights to health, self-determination, and autonomy. Further, vulnerable groups seeking contraception at public health facilities, including adolescent girls and women living with HIV/AIDS, encounter stigma and discrimination often resulting in denial of services by providers who are not held accountable for their actions.¹⁹

The goal of the report is to demonstrate the impact of restricting access to safe and legal abortion services and failing to clarify the current laws and policies on women's lives and to draw attention to the need for the government to act immediately to improve awareness about its laws and policies on abortions and to ensure that safe services are affordable, providers are well-trained, and health facilities are adequately equipped. The report further aims to persuade the government to uphold its human rights obligations,²⁰ and act urgently to reduce the numbers of preventable deaths and injuries due to unavailable contraception and unsafe abortion.

METHODOLOGY AND STRUCTURE

Methodology

The testimonials in this report were compiled from information obtained during interviews that took place in Uganda in March 2012. The interviews were conducted within Kampala and Mubende District by students from the IWHRC at Georgetown University Law Center—as part of the coursework for a ten-credit clinical course developed and taught by Professor Susan Deller Ross, and co-taught by Aparna Polavarapu, former teaching fellow at the IWHRC. An institute associate at the O’Neill Institute also conducted the interviews with the students and all interviews were based on a comprehensive qualitative questionnaire.

Student interviewers were accompanied by supervisors from the IWHRC, the Center, and Ugandan attorney alumnae from LAWA, with two supervisors present during each interview, one from LAWA and one from either the IWHRC or the Center.

The interviewees were mainly women who had gone through unsafe abortions or unplanned pregnancies due to lack of access to contraceptive methods, or had close family members who had similar experiences. In addition to those who spoke based on their personal experiences, other stakeholders, including medical practitioners, nurses, law enforcement officers, lawyers, government officials, and representatives of non-governmental organizations and international development agencies, were also interviewed.

Informed consent was obtained from all interviewees, who also agreed to the time and location of the interviews with due regard paid to privacy and confidentiality. Each interviewee was informed of the subject matter of the report and the goals of the interview. Interviewees were reminded that they were free to refrain from answering any questions and could end the interview at any time. Some interviewees granted express permission to use their names in this report. The names of those who asked not to be identified have been changed. Although some interviewees authorized the use of their names, to ensure their safety the authors have used their discretion in changing their names when deemed necessary.

Interviews were audio recorded after obtaining the interviewees’ consent and were subsequently transcribed by the students. The testimonials in this report were developed from the transcripts and audio recordings.

In the course of assembling and editing dozens of hours of transcribed interviews that make up this report, some edits were made to fix grammatical errors and enhance the clarity of the stories as they were told to project interviewers. In no way was any participant’s language changed in a way that would have altered the meaning of his or her statement.

Structure

More than 80 interviews were conducted and recorded. Of these, about 40 contained extensive information about the impact of unsafe abortion in Uganda and the challenges women face in accessing and using contraceptives.

Ultimately 31 testimonials have been documented in this report, each representative of many more in which the experiences shared were similar. The others have not been included to minimize repetition and to accommodate a wide range of experiences.

The testimonials are categorized into two types. The first focuses on women’s personal testimonies and key stakeholders’ perspectives on the impact of unsafe abortion. The second highlights both women’s personal experiences with unplanned pregnancy due to lack of contraceptive use, which in some instances resulted in unsafe abortion and death, and professionals’ ideas about the cultural attitudes and governmental problems that create this situation and the need to improve women’s access to reproductive health services.

TESTIMONIALS

A. THE IMPACT OF UNSAFE ABORTION ON WOMEN AND FAMILIES

Unsafe abortion is one of the most easily preventable causes of maternal death and disability. Where death does not result from unsafe abortion, women may experience long-term harms such as uterine perforation, chronic pelvic pain, or infertility. As noted in the introduction, Uganda has a very high incidence of unsafe abortion. This situation is sustained by the government’s failure to ensure adequate access to safe and legal abortion services and to raise awareness about the relevant laws and policies, which are more expansive than most know.²¹

Yet Uganda has ratified a broad range of international and regional human rights treaties that contain rights guarantees requiring states to eliminate preventable maternal deaths and address the causes of unsafe abortion. Among these are the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of the Child, and the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (Maputo Protocol).²²

The committees that oversee compliance with the international treaties have all characterized high rates of maternal mortality caused by unsafe abortion as violations of the rights to health and life, and have explicitly asked states to review legislation criminalizing abortions.²³ With respect to Uganda, the Committee on the Elimination of Discrimination against Women (CEDAW Committee), which monitors compliance with CEDAW, has noted with concern that maternal mortality rates in Uganda remain very high, “with clandestine abortions being a major cause thereof.”²⁴ Further, restrictive and unclear abortion laws discriminate against women on the basis of sex, age, and economic status, violating the right to be free from discrimination guaranteed in Article 2(1) of the Maputo Protocol.²⁵

Restricting or hampering access to a medical procedure that only women need exposes women to health risks not experienced by men, because only women incur the direct physical and emotional consequences of an unwanted or risky pregnancy. Further, adolescent girls and low-income women are less likely to have the resources to access safe services in Uganda, or to travel abroad to receive them. Poorer women are forced to have clandestine abortions, often in unsanitary conditions, at the hands of untrained practitioners, greatly increasing their risk of abortion-related complications and death.²⁶

Decisions from the committees that oversee compliance with international human rights treaties further confirm that denying access to safe and legal abortion violates fundamental human rights. For example, in *KL v. Peru*, the Human Rights Committee, which monitors compliance with the ICCPR, determined that a state’s failure to ensure women’s access to therapeutic abortion was a violation of the right to be free from cruel, inhuman, and degrading treatment.²⁷ Further, in *LC v. Peru*, the CEDAW Committee held denying access to therapeutic abortion constitutes discrimination.²⁸

The testimonials below expose several violations of women’s reproductive rights and underscore the need for Uganda to act urgently to uphold its human rights obligations and reduce preventable maternal deaths and injuries. They highlight the need for the government to increase awareness about its laws and policies on abortion, and to ensure that safe services are affordable, and health facilities are well-equipped and staffed with skilled providers.

PERSONAL TESTIMONIES

PREVENTABLE RISKS OF MATERNAL INJURIES AND DEATH

HAJARA²⁹

Hajara and her teenage daughter live in Kampala. They did not know what to do when her daughter became pregnant and desperately needed an abortion.

“[M]y daughter was at school and she got pregnant,” says Hajara. Hajara’s daughter sought out a clandestine and unsafe abortion without her mother’s knowledge. “I think they [the unsafe abortion providers] did some cheap things to try to abort. I think it took too long. She hid away for some days. And then one day she thought she was about to die.”

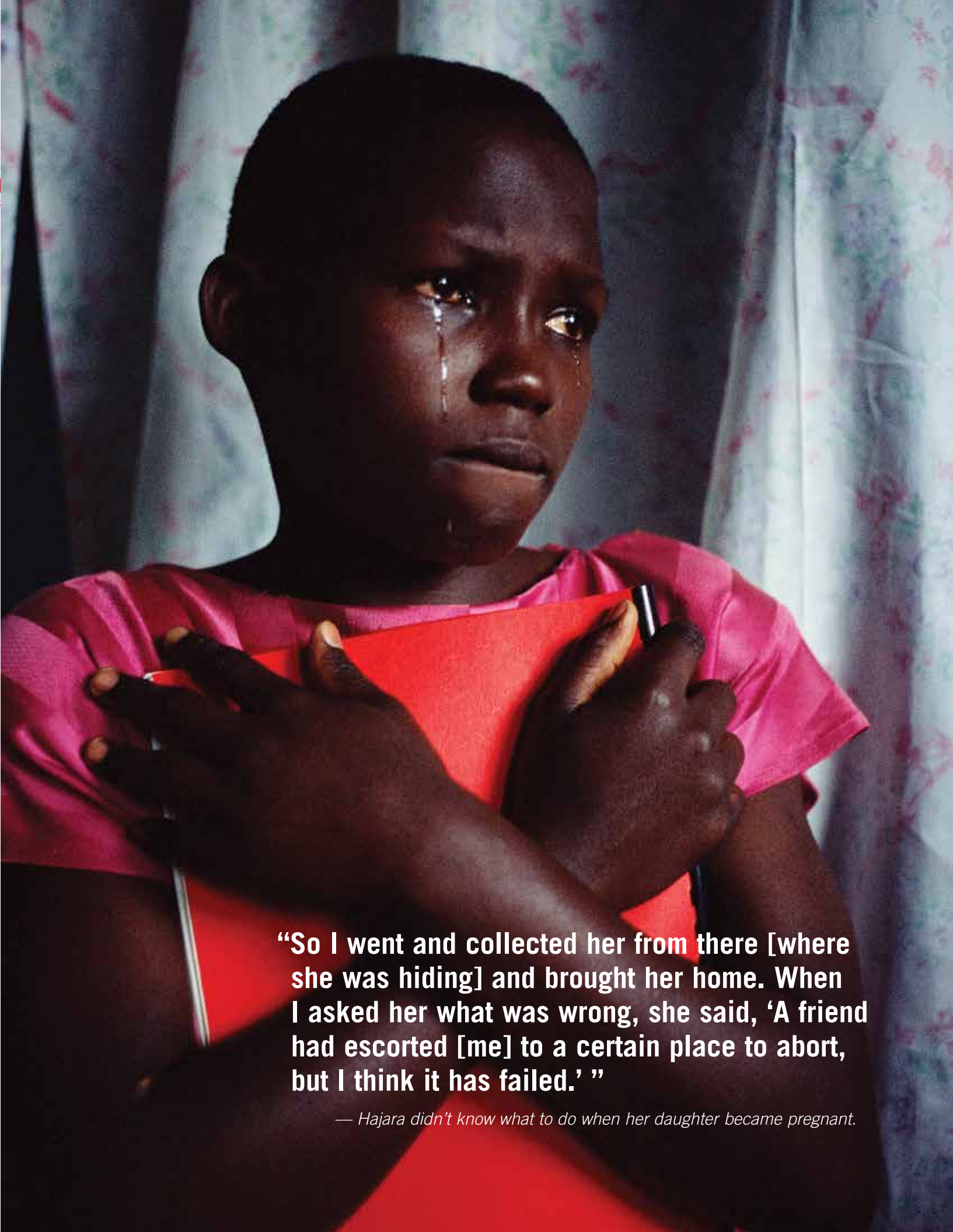
Luckily, some neighbors found her and informed Hajara where she was hiding. “So I went and collected her from there and brought her home. When I asked her what was wrong, she said, ‘A friend had escorted [me] to a certain place to abort, but I think it has failed.’”

Hajara found the unsafe abortion providers and threatened to take her daughter to the police to report what had happened. At this point, she says, “They said, ‘Please Madame, don’t take her to the police, let us try to help her.’” And they ultimately terminated the pregnancy. She acknowledges that her daughter could have died the way many have from unsafe abortion, particularly schoolgirls.

She is certain that it’s time to change the law to expand access to safe and legal abortions. “[I]f we change the law . . . I think it would save the girls’ lives.”

“So I went and collected her from there [where she was hiding] and brought her home. When I asked her what was wrong, she said, ‘A friend had escorted [me] to a certain place to abort, but I think it has failed.’ ”

— Hajara didn’t know what to do when her daughter became pregnant.



ELIZABETH³⁰

Elizabeth used to be a medical officer at Mulago Hospital, which also provides PAC. She was surprised to one day hear from her own sister, Martha,³¹ that she was at the hospital and had severe pains.

When Martha told the nurses about her pain, and the fact that she once had an abortion, the nurses assumed that she had had an illegal and unsafe abortion this time and practically abandoned her in the reception area. “She was kept there until past midnight, when I was able to contact a colleague, and they managed to take her to [the surgical] theatre. And I’m a medical worker and she’s my sister. But it took them this long, and she was in this pain. And even when she was on the [recovery] ward, she was stigmatized.” In the end, her surgery confirmed that Martha’s pain was caused by a burst dermoid cyst in her ovary.

Such hostile treatment, even in the face of serious health issues, is too common. “I’ve been in those clinics, the [PAC] clinics, even in the main hospital, and it’s not what you would call a friendly service to these people,” says Elizabeth. “Women come as a last resort. Most times, [these women tried] back-door clinics before they come to the qualified health service.”

Too often, doctors and nurses judge their patients with no sympathy for them even though they are seeking a necessary reproductive health care service such as PAC. “The unfriendliness I was talking about is to do with the PAC,” says Elizabeth. “In the clinic where people have had incomplete abortions and they come, most likely they’ve been perforated or they have complications, and instead of being assisted right away, they are grilled and asked, ‘How did it happen? Is this the first one?’”

For Elizabeth’s sister, one such experience was enough. Although she later experienced complications, she refused to return for care. According to Elizabeth, “[S]he told me, ‘I’m not going back to hospital. Whatever it means, I’m not.’”

MAUREEN³²

Maureen, a maternal health advocate, still remembers both the unsafe abortion and the deafening silence that ultimately took her cousin’s life. **“I had a cousin who actually passed away because of [unsafe] abortion** when she was at university in first year. It was, I think, done by a health worker [but] [g]iven that it was done in hiding I think that the health worker was in a hurry to get out and go. He pierced the girl’s intestines.”

“She developed diarrhea,” says Maureen, and though “she started getting stomachaches, she kept quiet. She took some self-medication hoping that she would improve.” But she did not and this went on for one more week.

“When she realized it was getting intense that’s when she told and was admitted [at a health facility].” In order to avoid being stigmatized, Maureen’s cousin told the health workers there that she had malaria, so they gave her malaria treatment. When her condition became worse, only then did she disclose that she had an unsafe abortion. “By that time, it was late. She was referred to a referral hospital which [was] in Jinja and in Jinja they said, ‘We can’t handle this,’ and she was brought to the national referral [hospital] here in Mulago.”

Maureen’s cousin was admitted at the hospital for a couple of days and went through two surgeries. But they were not enough to save her life.

“I believe that if she had had the alternative access to contraception she would have taken contraception and maybe not become pregnant,” Maureen says.

Maureen thinks contraception is very important in order to avoid unwanted pregnancies. She believes the government should make more information available, especially about emergency contraception. While emergency contraception is provided in public health facilities, some health care workers don’t provide it because they haven’t been trained about it. She has found in the course of her work that there is very little knowledge of emergency contraception, particularly among women who live in rural areas.

Even with contraception available, there will be failures, and Maureen notes that many women are very afraid of pregnancy because of the consequences for their lives: “We have asked what young people fear most between pregnancy or HIV. They say pregnancy. It is not only the young people. Even adult women, they fear pregnancy. HIV comes second.” For these women, criminalizing abortion will not stop the procedure; it will only continue to expose women to increased risks of injury and death. Maureen explains that women find ways: “Because it is [criminalized] it is not well known exactly where to go for these services. But it is known that women use crude ways. They insert whatever objects they take, herbs, whatever, to force [the] fetus to come out.”

RACHEL³³

Rachael, 28, knows the exact clinic to go to in her community if she needs an abortion. “It is common knowledge,” she says.

However, the medical practitioners’ fear of prosecution means that some women are turned away to avoid exposure. Those who are willing to perform safe abortions exercise enormous leverage over the women who seek their services.

“In fact they have so many clients that [they send] away some of them,” says Rachael. She adds, “[The doctor] does it stealthily. That’s why sometimes he chases away some clients. Definitely some people will talk that he does it. So he also has to be careful.”

With limited options, women can find themselves paying exorbitant amounts for reproductive health care. The clinic Rachael knows of often charges between 150,000 and 200,000 Uganda Shillings (UGX), and sometimes up to UGX 300,000, to perform an abortion.³⁴

Women who cannot find a doctor or pay for an abortion turn to other options. “Some of them use Omo powder,” says Rachael. “This is a detergent, and the person sits in a solution of detergent and the fetus aborts. Some of them take Jik and the fetus aborts. Jik is a bleaching solution. Some use a local plant called ananda. Some of them use aloe vera. They boil many leaves of aloe vera, and they take the concoction and then they drink it. Those are the ones I have heard.”

**Women who cannot find a doctor
or pay for abortion turn to other options.**



Some measures are even more extreme and dangerous. “Except if someone takes the worst measure and that is pouring acid on your stomach. There are so many demonstrations nowadays and the police use tear gas. You can go to an area where there is tear gas. The tear gas has an effect of making someone abort, so that is something that can be used.”

TEWI³⁵

Tewi was 31 when she discovered she was pregnant. She had two children already (now 16 and 10) from a marriage that was falling apart. In addition, she and her husband were both living with HIV. Her husband made his feelings about the pregnancy very clear. “He said he was not responsible. He said, ‘I don’t want. I don’t want kids,’” says Tewi.

“‘Now you are going to bring kids who are [living with HIV].’ He told me that I needed to cater for that kid myself.”

Tewi was lucky. She had the option of paying for a safe abortion since she had some personal wealth. “I had my money,” she says. “I asked my friends to find a doctor who does it. I went and made an appointment. They charged me 200,000 Uganda Shillings. It was damn expensive, but I had to do it.”

The problem of unplanned pregnancy is so prevalent in Uganda that women value any information that might help them. “I had heard before that so-and-so doctor does [abortion]. So when I heard this, I kept it in mind,” says Tewi. “When [I got pregnant], I recalled fast that it was this clinic in this place, so why don’t I try? I went to the clinic, and talked to the receptionist and asked to speak to the doctor.

She said, ‘Okay, what is the problem?’ So I told her, and she said, ‘Okay, if that is the case, you come in the evening, I will talk to him.’ She knew because that was the system. When I went back, I saw four people, who were all there for the same act. I waited for my turn, and it was my turn, and I went and got it done that evening.”

The abortion did not have any ill effects. Tewi did not know of the doctor’s exact qualifications, but “from what I know, I heard his clinic did the job. If I heard he didn’t, I would not go.”

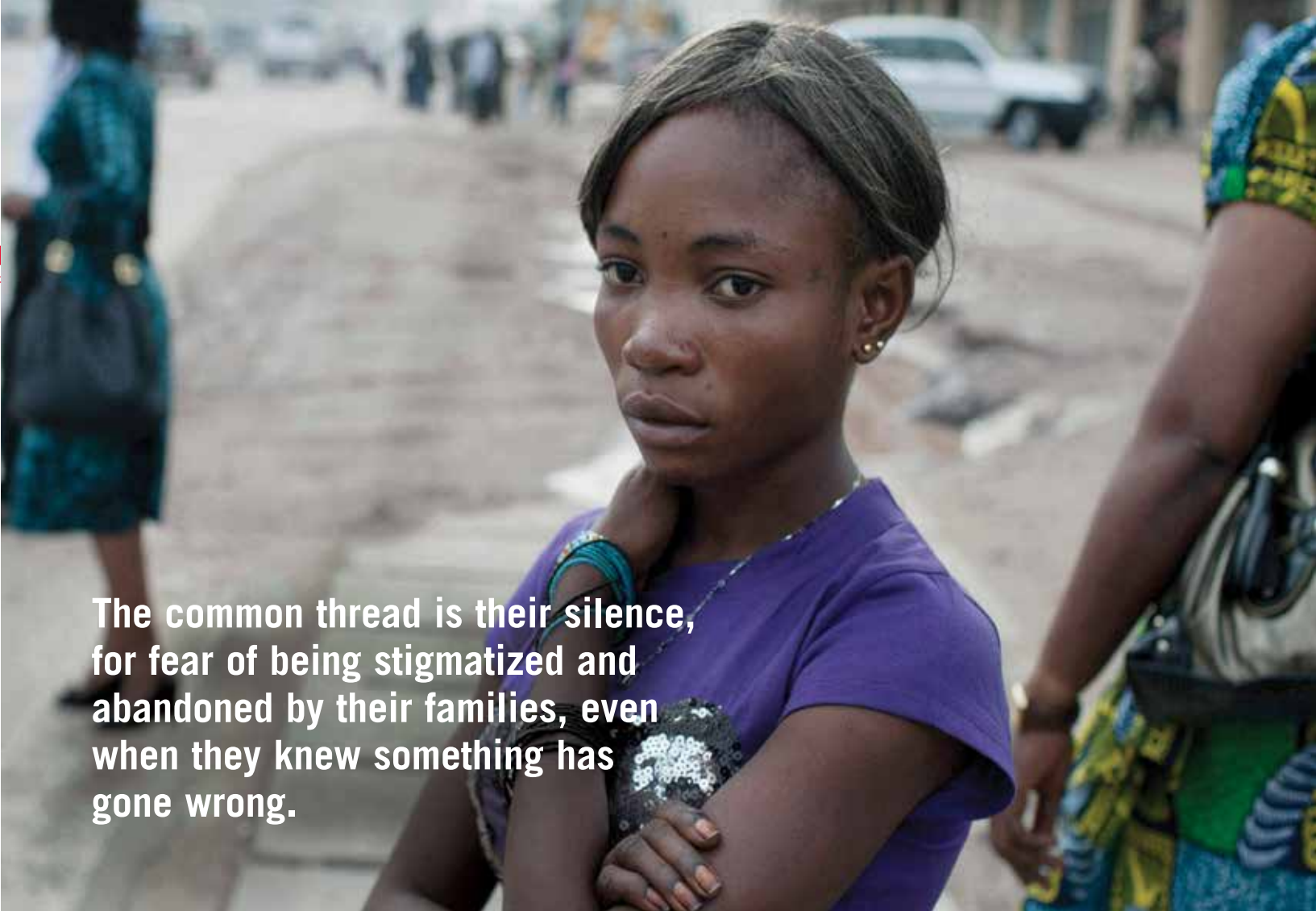
Despite the cost, Tewi says she did not try and negotiate with the practitioner. “[S]ometimes, they will tell you that they will stop from giving the abortion,” she says. “It is up to you—you want or you don’t want. Because he is, of course, risking himself.”

Tewi says her experience is not something she would share openly. “Of course it is not allowed,” she says, “so you just need to keep quiet. You do not say you went to a clinic, you just stay quiet. It is still a taboo, you cannot talk about it.”

INCREASED RISKS OF INJURIES AND DEATH FOR ADOLESCENT GIRLS BASED ON FEAR OF LOSS OF FAMILY SUPPORT AND EDUCATION

NICKI³⁷

The stakes for an unplanned pregnancy are especially high for young women still in secondary or high school, who risk expulsion and the end of their education if the



The common thread is their silence, for fear of being stigmatized and abandoned by their families, even when they knew something has gone wrong.

pregnancy continues. Nicki is a student in Kampala, and a number of her friends have had unsafe abortions. The common thread is their silence, for fear of being stigmatized and abandoned by their families, even when they knew something has gone wrong.

“I used to live in a place where a girl got pregnant and she used Omo, the detergent. She drank it with warm water and ended up bleeding. Her parents didn’t know, nobody knew, only her friends. She had to be taken to a clinic to check on her.”

“Another friend used tea—majan—leaves. She took a first glass—it’s sour. It didn’t work. She took a second one. She ended up falling down, bleeding, asking for help. . . . In that process she was injured, she lost a lot of blood. She was taken by a relative to a healthcare facility.”

“I think they are scared of telling anybody, of being pregnant. They will be called stupid girls in the society, and irresponsible people. They also chose [to abort] because they wanted to keep respect of family. [They] don’t want their mother and father to know, to be chased away from the home. They do not want to be denied their rights at home.”



HUSAIN³⁸

Women are not the only people who know where to obtain clandestine and unsafe abortions. Husain goes to high school in Kampala, and says everyone knows where to go should they need to procure an abortion. That information usually comes with rumors about schoolmates.

Husain says, “I’ve heard of it, maybe a friend, [or] some guys are telling me, ‘That girl has gotten an abortion.’ I asked [where they go, and] they tell me, ‘Like any clinic. You just go to any clinic.’ If they can’t [provide an abortion], maybe they can direct you to a person who can. And even my brother was telling me, ‘You should not be scared. If you make a girl pregnant, you can just come to me and we can do an abortion. I can take you to someone who can do an abortion.’”

But Husain says these abortions are not safe because the providers “are not recognized” and do it secretly. Asked whether it would be better for these secret and unsafe procedures to be made more open, to enhance safety, Husain says, “I think it’s fine [to make them more open].” He says he cannot bear to see a friend his age suffer when she could have avoided such suffering by having a safe abortion.

PERSPECTIVES FROM KEY STAKEHOLDERS

INCREASED EXPOSURE TO ABORTION RELATED STIGMA AND ITS TRAGIC CONSEQUENCES

JOSEPHINE³⁹

The misperception that abortion is completely illegal or only allowed to save a woman’s life in Uganda has not reduced the incidence of women seeking an abortion. The services have been driven underground instead, making it difficult for vulnerable groups—adolescent girls, low-income women, women without any formal education—to access safe abortion services.

Josephine, a Ugandan women’s rights lawyer who works with a nonprofit organization, has on several occasions tried to help young women navigate the complex process of gaining access to safe abortion.

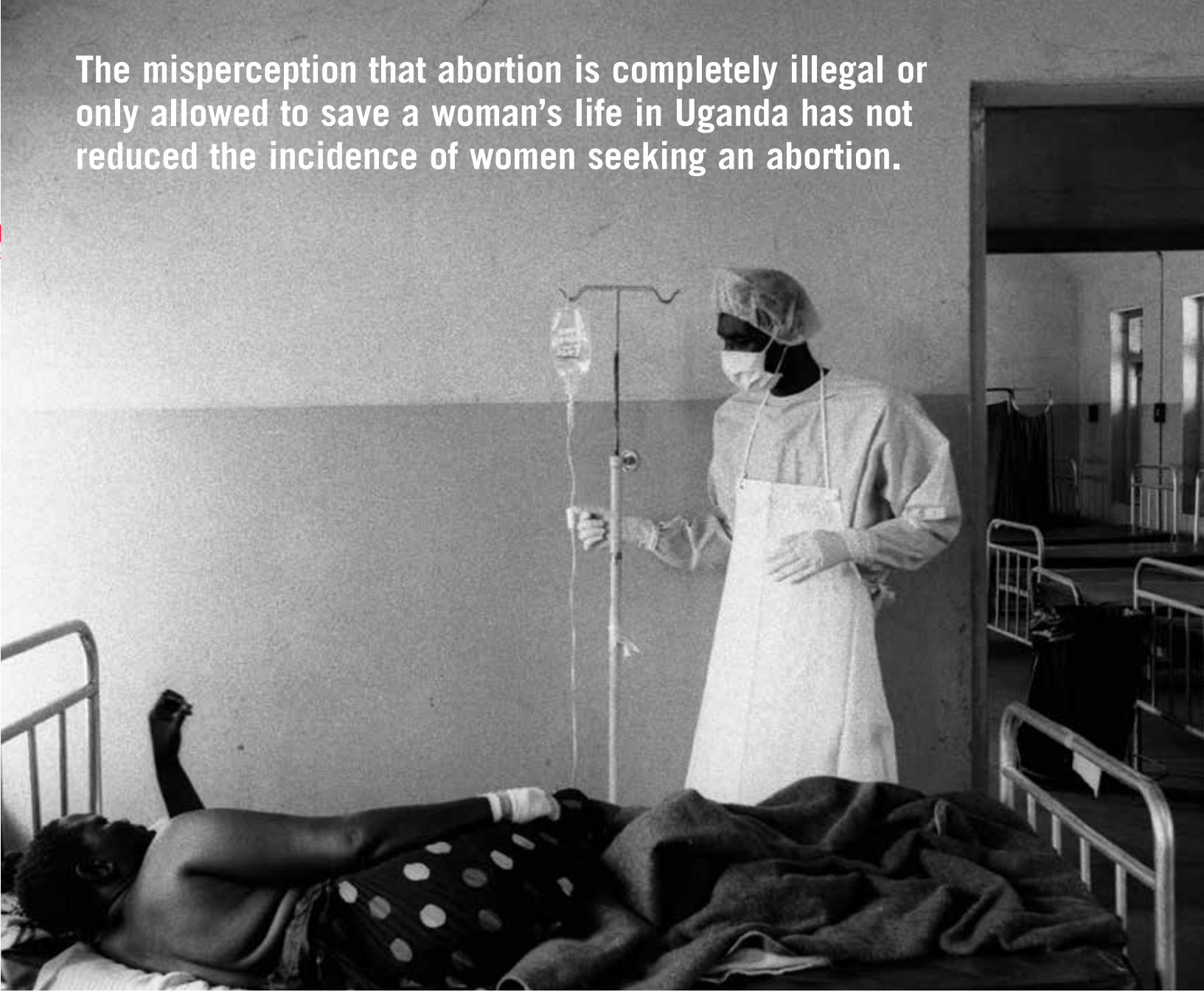
“You just give them a small piece of paper after making the contact,” she says. “Then you write maybe Room Five, that’s all they take. The rest of the words you tell them: ‘Go to Ward Four or Ward Number Three.’ And you give them a small piece of paper with just the number, so that if anybody gets hold of it, they wouldn’t know what the whole thing is all about.”

Finding doctors willing to perform the procedure is no easy task. “You have to talk to them [quietly], or you can say, ‘Hey, I want to meet you at such and such a place, you see here there is this problem.’ Of course, they will say, ‘But why doesn’t the girl carry it to full term?’ So you have to explain.”

The reality is that those with money and connections have an easier time of securing reproductive health care. “There is a certain ward [in a hospital] where it is done,” says Josephine. “It’s not secret!”

But even with privilege or a strong position in society, the stigma is enduring and powerful. “If I were to get pregnant and I wanted to abort, I wouldn’t be telling all of you,” says Josephine. “I’d get to a friend and tell them, ‘You know what, I have a problem, how do we solve it?’ You do it secretly and you’re done with it. Because of that fear, I think, that’s why you find some people who are not fortunate to get connected to the right people to terminate the pregnancy; they resort to traditional methods, which may turn out to be unsafe.”

The misperception that abortion is completely illegal or only allowed to save a woman’s life in Uganda has not reduced the incidence of women seeking an abortion.



It does not have to be this way, Josephine points out. The Reproductive Health Guidelines and provisions within the Penal Code stipulate the grounds on which abortion is legal in Uganda.

“But the problem is people not knowing that it can be lawful [under these specified circumstances],” says Josephine.

MS. PETERS⁴⁰

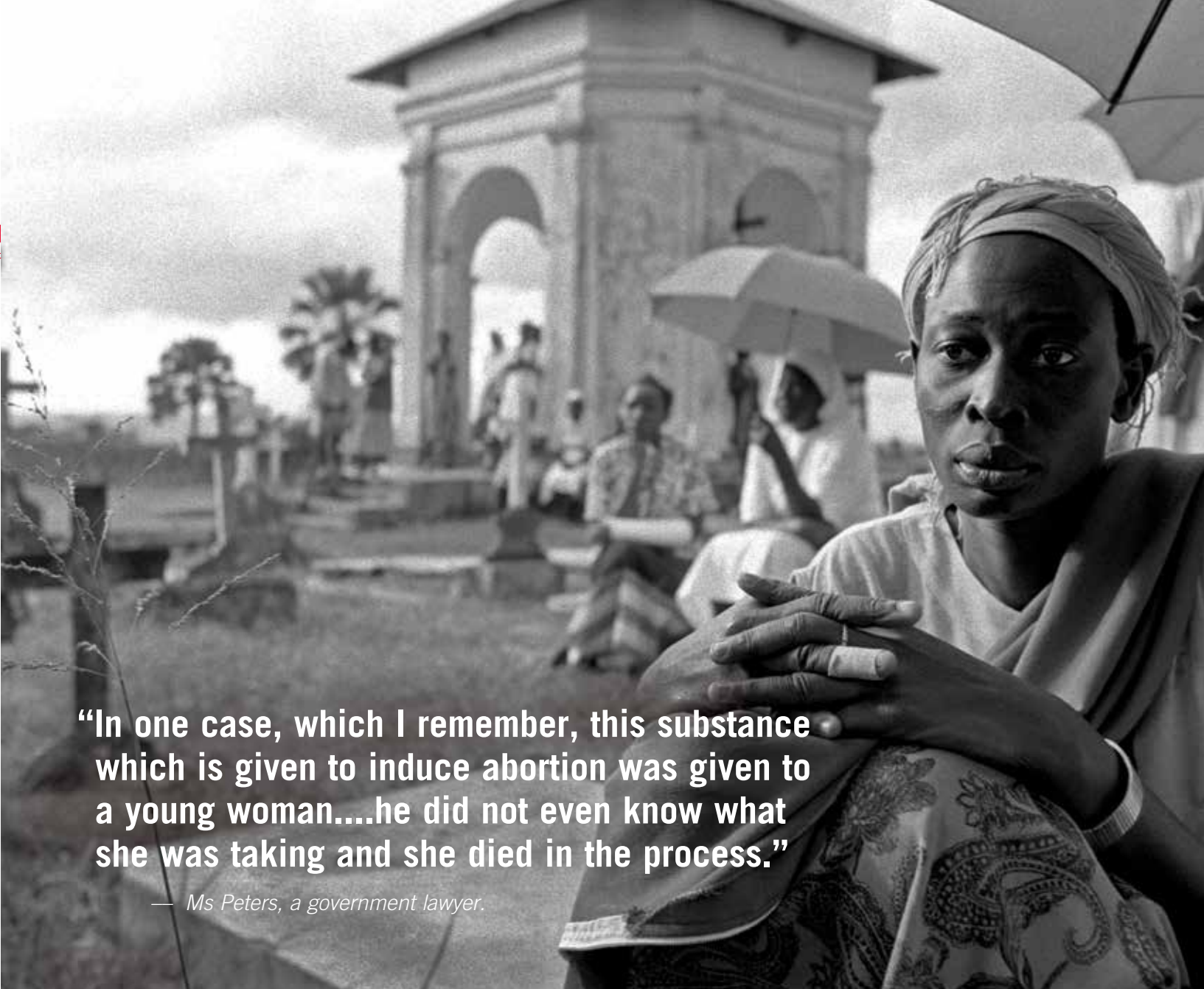
Ms. Peters works as a government lawyer and has prosecuted cases pursuant to Sections 141, 142, and 143 of the Penal Code, which criminalize the procurement or provision of unlawful abortions.⁴¹ “Many people believe in herbal methods of abortion in this country because they cannot go to medical facilities or pay someone to do a safe abortion since it is not legal,” she says, echoing a widely held misconception that there is an absolute prohibition on termination of pregnancy in Uganda.

Through her work, Ms. Peters sees firsthand some of the dire consequences that arise when women are forced to rely on the “herbal method.” “In one case, which I remember, this substance which is given to induce abortion was given to a young woman,” says Ms. Peters. “[S]he did not even know what she was taking and she died in the process. She did report to her sisters that she went to this guy, and he was the one who gave her this thing, and immediately she started vomiting. And after a while she started bleeding.”

“I had another case in Mbarara, where again the victim died. He [the unsafe abortion provider] brought her to a lodge in Mbarara town, and it is not known what method he had her use, but she ended up dead in that lodge because of over bleeding.”

“There is another case where a medical facility in Mbarara was being used to procure abortions, and this girl went with her boyfriend when her pregnancy was quite big and obvious to many people. He took her to that health facility. But according to many people, he had already administered her herbs.... He administered some substance and by the time she reached the hospital she was so dehydrated. . . . The doctors, after seeing her situation, they put her on a drip to rehydrate her, but she still died on the third day.”

But Ms. Peters’ view is not restricted to her professional experience. Like many others in Uganda, she has also seen the consequences of clandestine abortion in her personal life. A young girl in her family became pregnant. The girl’s mother took her to an herbalist, who gave her some mysterious substance to drink that would allegedly induce an abortion, “and then when he didn’t see any response he started to use physical objects.” The herbalist’s actions nearly ruptured the young girl’s uterus, causing profuse uterine bleeding.



“In one case, which I remember, this substance which is given to induce abortion was given to a young woman....he did not even know what she was taking and she died in the process.”

— Ms Peters, a government lawyer.

Fortunately, the girl made it to the hospital early enough to survive the experience. Had this particular hospital not been able to provide her with adequate post-abortion care services, she would not have survived.

ROSELYN⁴²

Anyone working in Uganda's reproductive health services comes to recognize the fact that death is an everyday part of the job due to the high incidence of unsafe abortion-related deaths. Roselyn has been working in her community for years, and she has seen her share of women desperate for an abortion. Without access to safe abortion, they resort to useless and frequently dangerous methods, like herbal combinations.

Roselyn first experienced the tragedy of unsafe abortion as a girl. The school administrators "called us to see a girl who had died in my village," she says. The girl had taken chloroquine to end a pregnancy. "And then we did not take it seriously, we went away laughing, but that is how bad it is in Uganda."

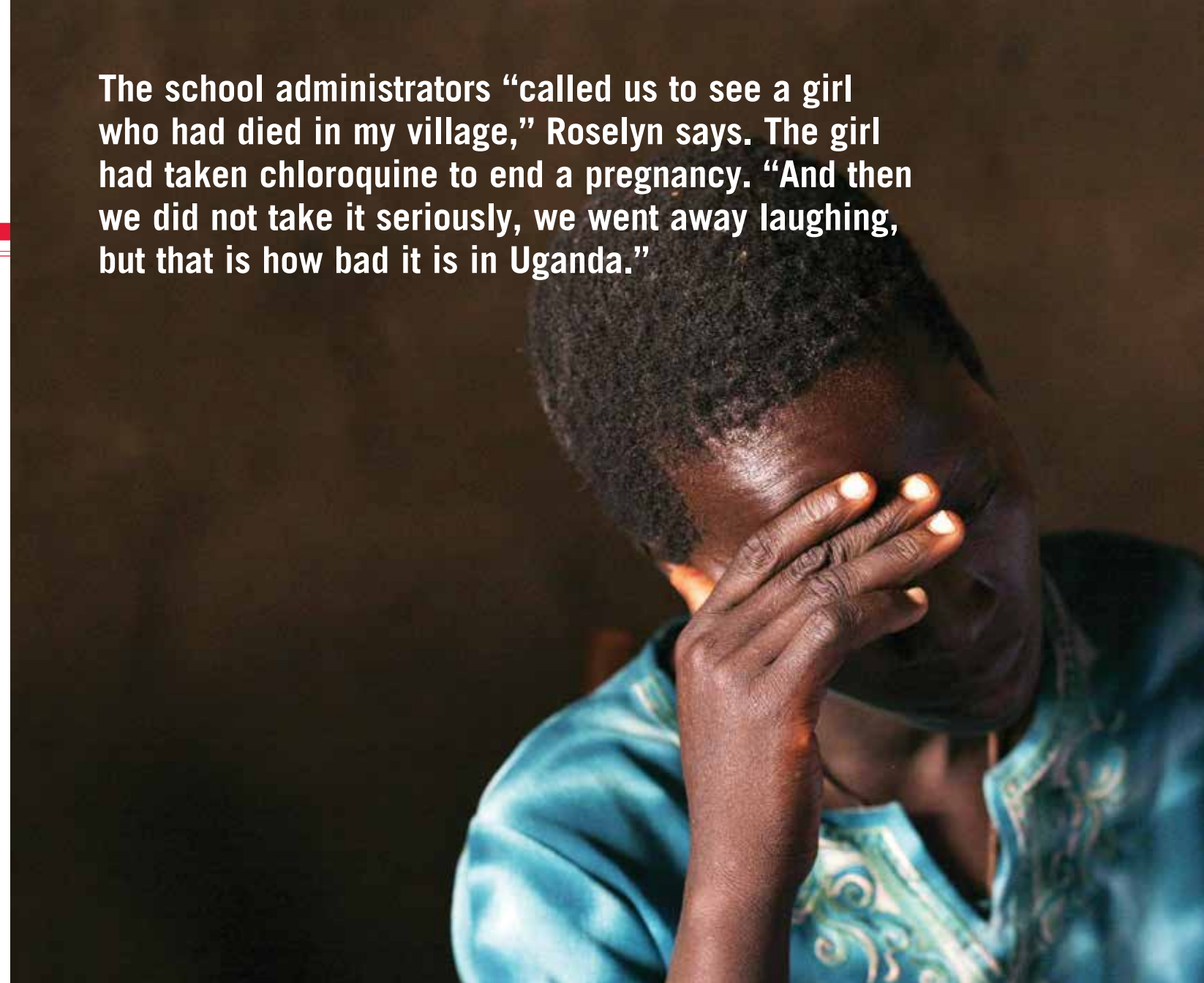
"I remember another case where the girl, she was told to keep hitting her stomach [with] a stone," says Roselyn. "They do everything! I heard of one recently, where they told her to use a stick and pass it through her birth canal, and hit until the [fetus] comes out."

The lack of reproductive health care and appropriate family planning information, including for men, has had widespread impact, especially in the presence of HIV/AIDS. "If the man is HIV positive and the woman is HIV negative, a discordant couple, the man will actually force the woman [to engage in unsafe sex]," says Roselyn. "Like so many cases we have seen in communities, the man does not want to follow the guidelines of the health facility, where you continue to use a condom. Gender and sexual-based violence is there." In these cases, the man's violence and lack of caring can lead both to the woman's HIV infection and to her pregnancy.

The government and international agencies have invested in provision of contraception, but inadequacies in government policies and programming—for example, failure to ensure equality in family relations and to involve men in family planning education programs—continue to limit women's contraceptive access and use in practice, as the example above shows. "Women in the rural communities cannot freely access family planning services," says Roselyn, too often "because they fear their husbands."

The school administrators "called us to see a girl who had died in my village," Roselyn says. The girl had taken chloroquine to end a pregnancy. "And then we did not take it seriously, we went away laughing, but that is how bad it is in Uganda."

This is not simply a problem for rural women, however. Roselyn believes the issue goes much deeper. "I think the mistake Uganda made was that it only addressed women," she says. "From the [beginning], family planning has been looked at as a woman's issue, and men have looked at it like that."



He particularly remembers one such case where a doctor was forced to remove a woman's uterus. "It is sad that if you had done the safe abortion, if you are empowered to do the safe abortion, you would not have had those problems."

– Dr. Collins Tusingwire speaking about unsafe abortions.

LACK OF ACCESS TO LIFE-SAVING CARE DUE TO INADEQUATE KNOWLEDGE OF THE LAW, FEAR, AND STIGMA

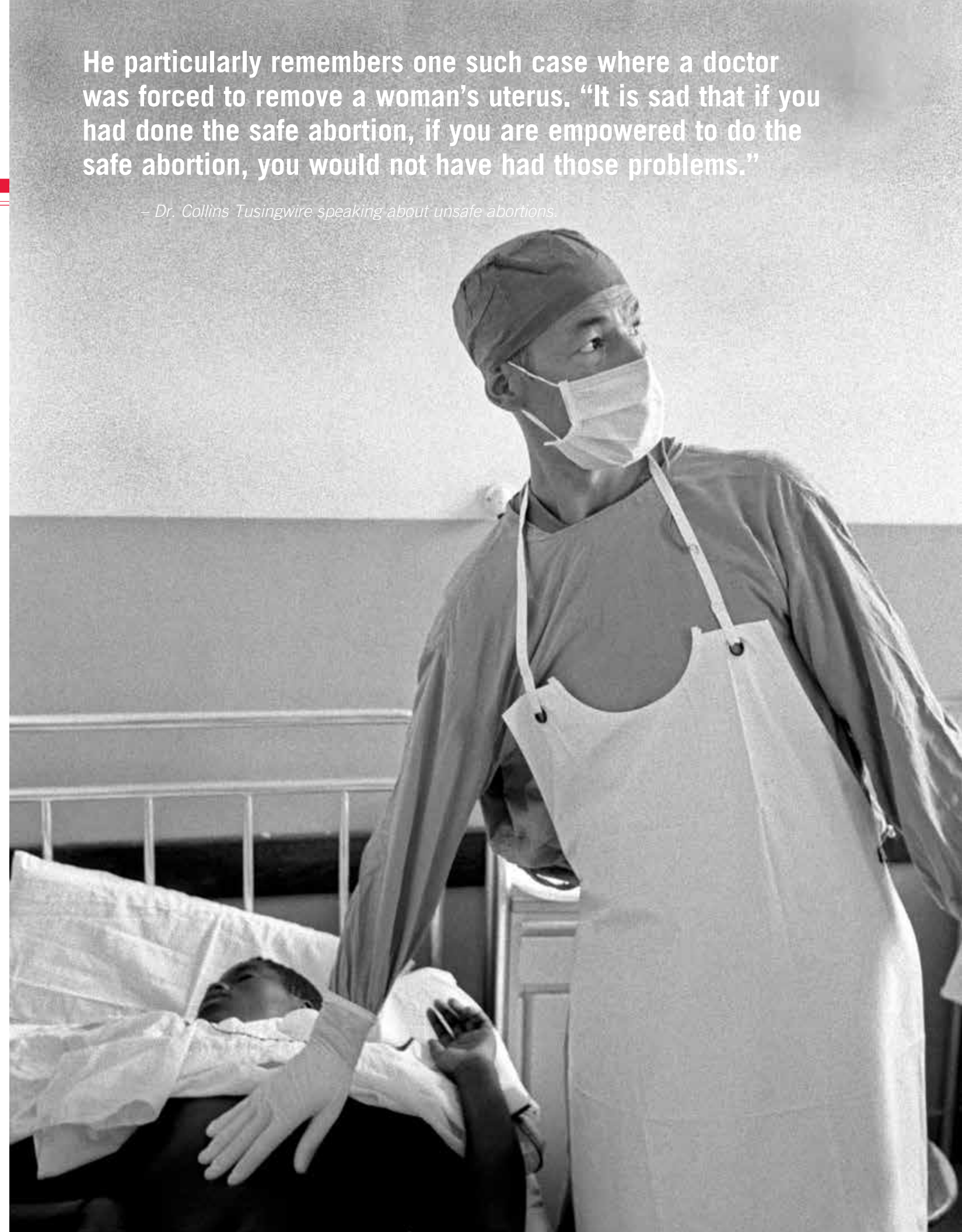
DR. COLLINS TUSINGWIRE⁴³

If Dr. Collins Tusingwire were only someone who coordinates HIV and emergency reproductive health care, his experiences with and perspective on unsafe abortion would be incredibly valuable. But as a senior medical officer in the Reproductive Health Division of the Ministry of Health, he has also been instrumental in the efforts to develop and disseminate the Reproductive Health Guidelines.

Those guidelines provide detailed information on the grounds under which abortion should be provided, including severe maternal illness threatening the health of a pregnant woman, cancer of the cervix, and women living with HIV who request termination.⁴⁴ They also identify cases of sexual violence such as rape, incest and defilement as grounds for providing abortion services.⁴⁵ There is currently little awareness of these grounds. There is also insufficient funding to facilitate the kind of distribution that such information requires, leaving too many people in the dark—both women and health care professionals—about possibilities for lawful abortion. Fear of legal ramifications is one of the main reasons women seek out unsafe abortion services and do not get the PAC they need. Dr. Tusingwire explained that the guidelines have been revised, and are waiting for printing, but the provisions on abortion remain the same.

"If you are discovered to have an abortion, you will be shunned in the courts of law, so definitely that makes you shy away," says Dr. Tusingwire. "Then by the time you go [to get help], it might be too late and post-abortion care can't work."

PAC is a free service in public health care facilities in Uganda,⁴⁶ but the government has focused on providing PAC services instead of addressing the problem at its root—by ensuring access to family planning services and safe abortions, which would in turn reduce complications and deaths arising from unsafe abortions. Dr. Tusingwire knows many doctors who have provided PAC to women who sought out unsafe abortions after those same doctors had refused to provide safe abortions. He particularly remembers one such case where a doctor was forced to remove a woman's uterus. "It is sad. It is sad that if you had done the safe abortion, if you are empowered to do the safe abortion, you would not have had those problems."



DR. ANDREW⁴⁷

Dr. Andrew has practiced gynecology in Uganda for 20 years. He has seen his share of victims of gender-based violence, of women who do not want to be pregnant, and of desperate women who take the matter of abortion into their own hands.

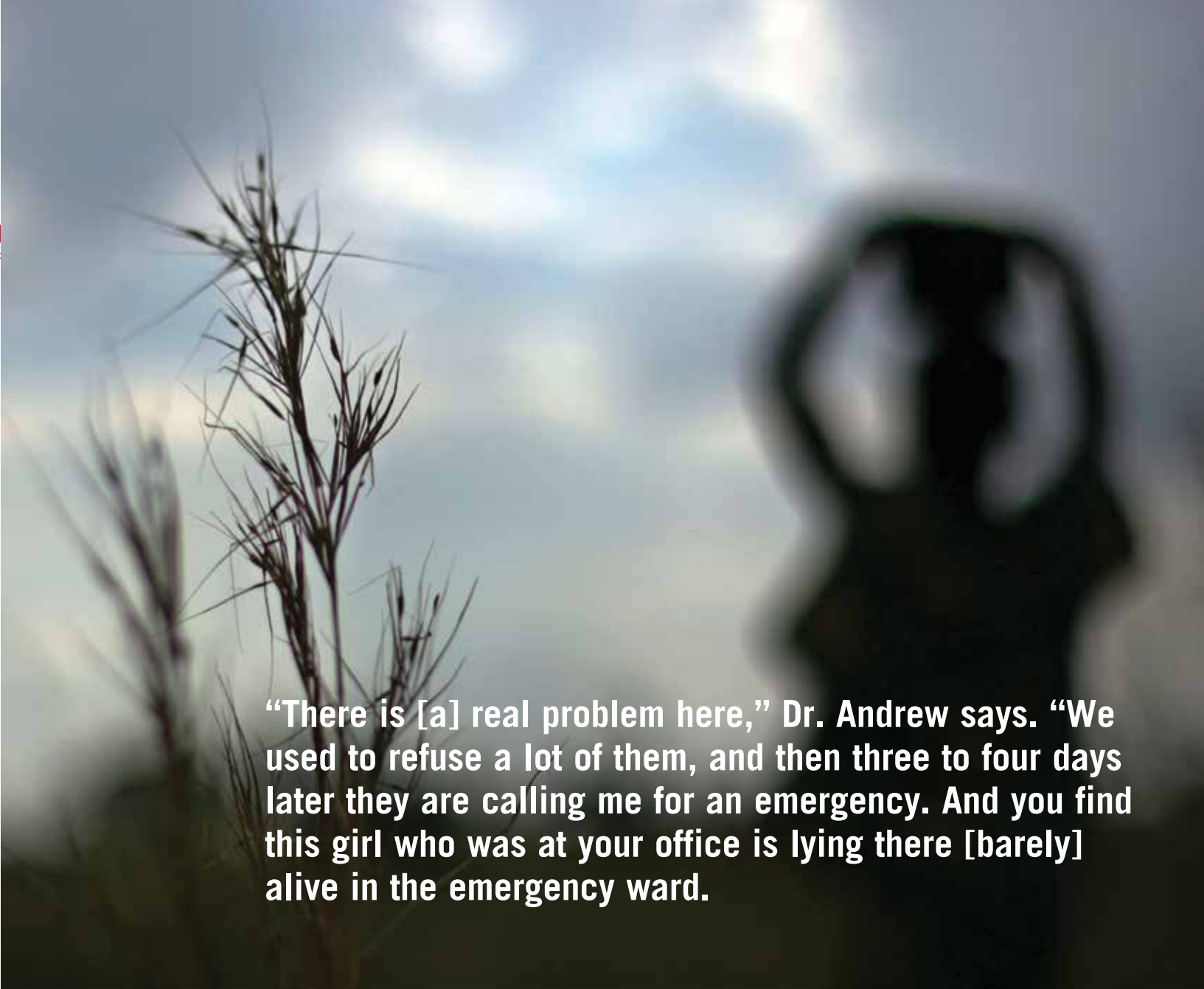
He has also seen signs of improvement. More women are getting contraception. Hospitals are better equipped to meet family planning needs. And the government has recently committed more resources to making sure women can get contraception when they need it. But the most promising transformation might be in his own attitudes to reproductive health care, especially if they can take hold throughout the country.

“With time, I have gone through an evolution, from saying completely ‘get out from my sight.’ [I would say that] because in our training, we were told that this is a criminal offence and then you don’t want anything criminal, and you don’t want to get involved. Over the last 15 years, I’ve had a bit of transformation from the work that I have been doing with these women to appreciate them a little bit more. ”

His change in perspective has led him to perform safe abortions without taking into account whether they would be deemed legal or not. He knows some doctors charge prohibitive amounts to perform an abortion, but he approaches the problem differently. “Sometimes I charge because they need medication, then they will need some medication or need some antibiotics,” he says. “I do not take money myself because that is not the reason I [do it].”

Why does Dr. Andrew do it? His reason is simple—to save the lives of women and girls, particularly the most vulnerable of them who often are the ones forced to rely on clandestine and unsafe abortion.

“There is [a] real problem here,” he says. “We used to refuse a lot of them, and then three to four days later they are calling me for an emergency. And you find this girl who was at your office is lying there [barely] alive in the emergency ward, and you have to provide emergency service. So you lose some [patients’ lives] and then you wonder [if] that is better than not helping them earlier.



“There is [a] real problem here,” Dr. Andrew says. “We used to refuse a lot of them, and then three to four days later they are calling me for an emergency. And you find this girl who was at your office is lying there [barely] alive in the emergency ward.

It is a transformation, it does not come abruptly.” “Others even will say, I came to your office for help and you refused. It touches you, especially since you know that she could be alive if you had treated her.”

PROFESSOR TAMALE⁴⁸

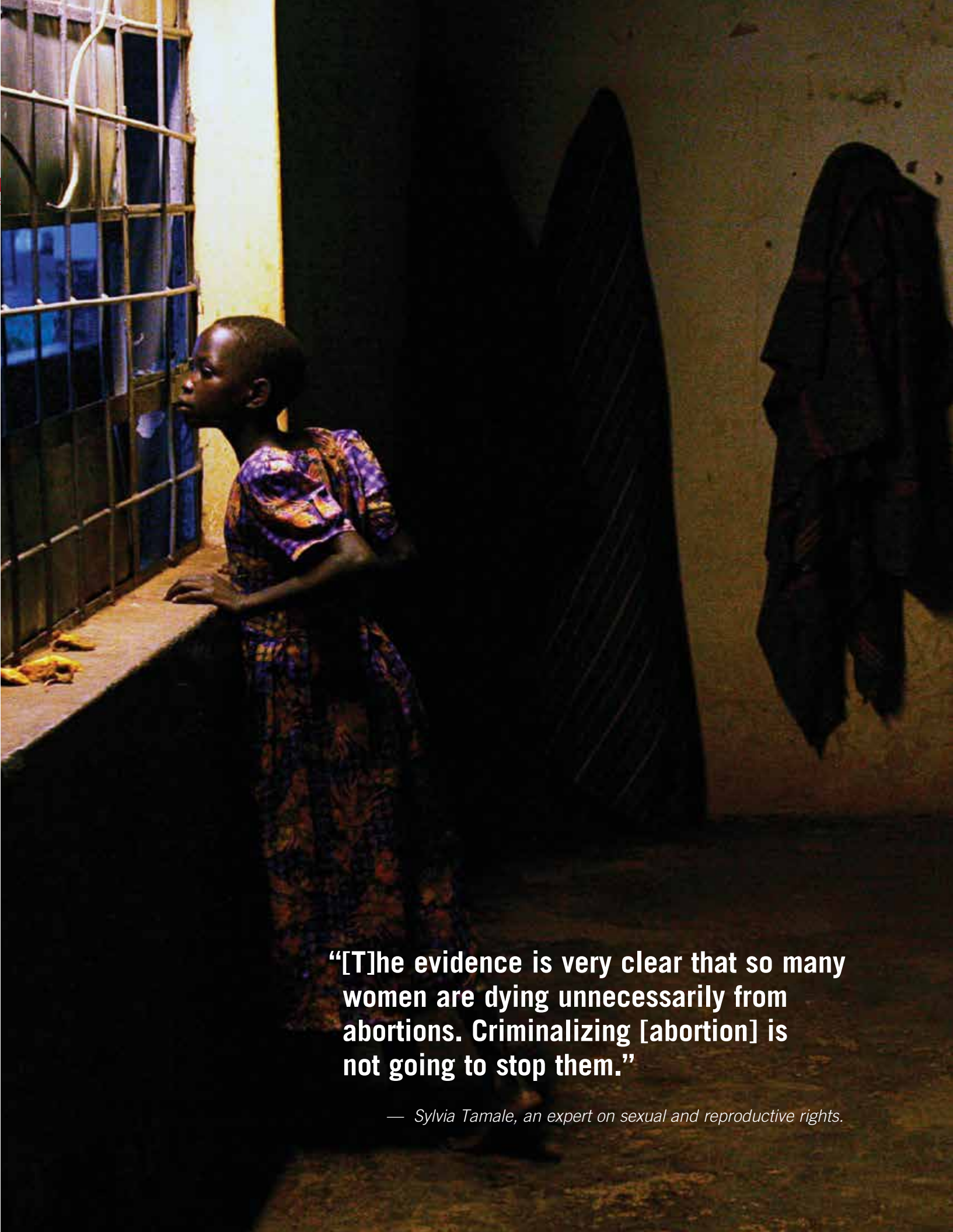
Clarity in Uganda's abortion law and policy will be tough to come by as long as the Ministry of Health's Reproductive Health Guidelines remain inaccessible.

"Very few people even within the Ministry of Health know about them," says Sylvia Tamale, a professor at the Makerere University School of Law, who is an expert on sexual and reproductive rights issues. "Why don't they publicize them? Even when you talk to people at the Ministry of Health, they don't know about them! So they were passed, but with very little publicity. It's like, we have these policies but there's no intention and no political will whatsoever to implement them."

The country's laws send a clear message. "When you criminalize abortion, the statement you are making is, 'We don't care about women's lives,'" says Tamale. "Because the evidence is very clear that so many women are dying unnecessarily from abortions. Criminalizing [abortion] is not going to stop them."

Women understand the ramifications of an unintended pregnancy. "You're forcing motherhood on these parents," says Tamale. "They are aborting for a reason, and you're telling them, 'We don't care.' I mean, you're not telling them, 'Carry that baby for nine months and when you deliver the baby give it to the state, the state will take care of it.' You're saying, 'Whether you like it or not, you must take care of that child.'"

Legalizing abortion, as well as expanding access to contraception, would go a long way to solving many of the country's problems, even going beyond health issues. "When you think about people's bodily integrity, whether male or female, people should ultimately have some choice, some decision, regarding how to lead their lives and to make choices about what to do with their bodies, and how to lead in their view what is a dignified life," says Tamale. "Apart from that individual choice of bodily integrity, when you look at the collective issue of women's rights, the decisions [about] when, how many, children they want to have, it's really part and parcel of women's rights. So, collectively and individually, it is extremely important to allow women to make those decisions."



"[T]he evidence is very clear that so many women are dying unnecessarily from abortions. Criminalizing [abortion] is not going to stop them."

— Sylvia Tamale, an expert on sexual and reproductive rights.

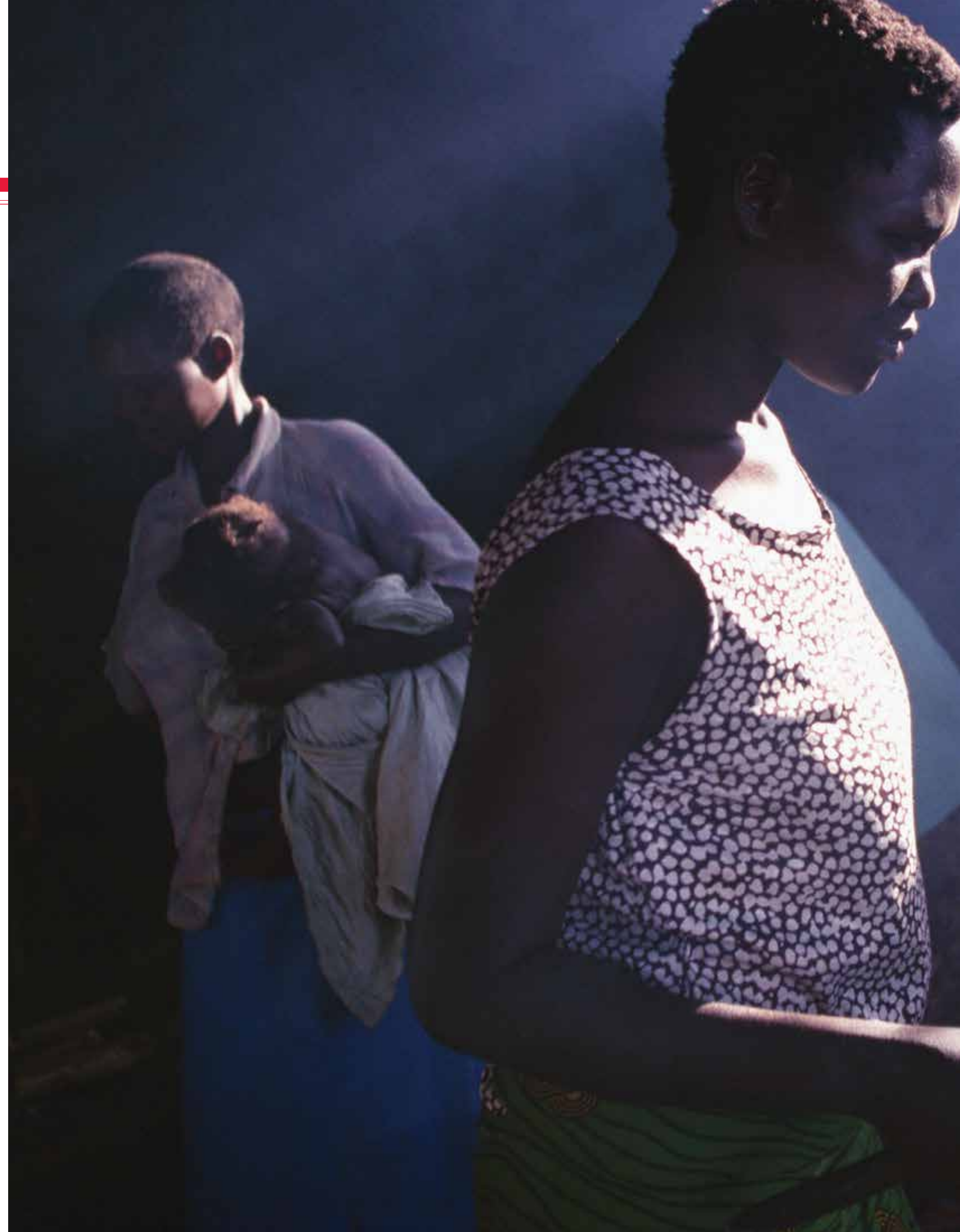
PROSECUTION AND IMPRISONMENT FOR ABORTION-RELATED CHARGES

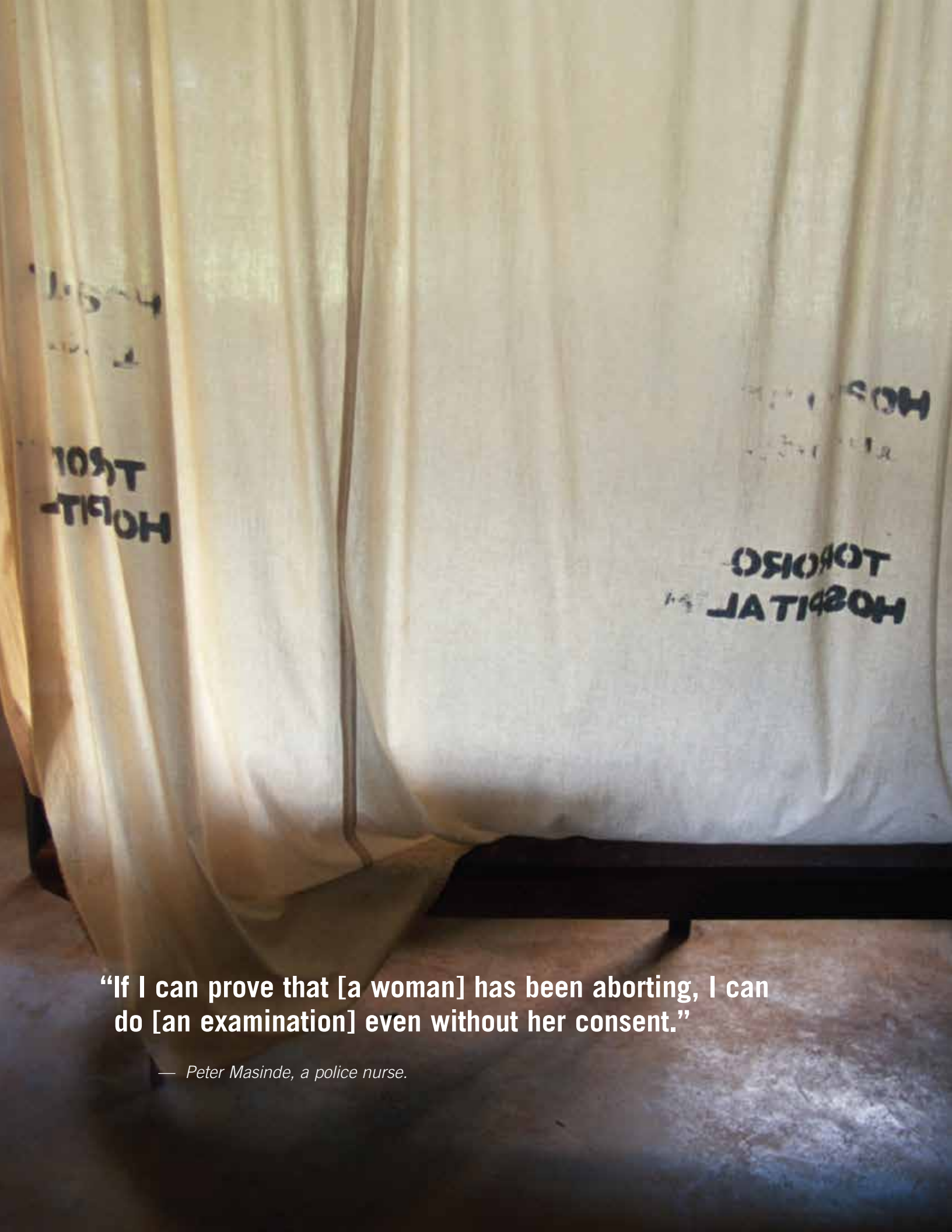
SARAH⁴⁹

Another consequence of the laws on abortion in Uganda is that women themselves can be prosecuted and imprisoned for terminating their pregnancies, even when they have suffered bad health consequences due to an unsafe abortion.

“There was a girl who aborted and so I was called,” says Sarah, a community activist with the Center for Domestic Violence Prevention. “I don’t know what she used but when she was brought here she was bleeding, very sick. She was treated but at the same time taken to prison.”

The girl was prosecuted and imprisoned for one year before being released.





“If I can prove that [a woman] has been aborting, I can do [an examination] even without her consent.”

— Peter Masinde, a police nurse.

PETER MASINDE⁵⁰
“All abortion is criminal.”

That is what Peter Masinde, a police nurse, has been taught, including as part of his police training. He has seen women arrested, charged, and arraigned in court for abortion-related offenses, including two cases in the past year.

The details of one case have stayed with him. “She wanted to abort. But the one who [did it was not] successful,” says Masinde. “He used sharp instruments. He tried to injure the cervix; the uterus. Then the woman started bleeding. The bleeding was serious until [relatives] took the patient to Mulago [a hospital].” They decided not to come to the police. “They fear police.”

Their silence had little effect. Someone reported both the woman and the person who provided the unsafe abortion. It is not clear who reported them to the police.

The police sometimes find out about cases of women attempting to seek abortion through tip-offs from relatives or community members. “Sometimes you just hear. ‘I have here somebody who has been doing this or that, she is trying to abort,’” says Masinde. “That is when we have [to] arrest them. We send women police to go and pick them up.”

Masinde performs the examinations, which are often invasive and involve the use of a speculum. Although these examinations raise concerns about violations of the women’s rights to dignity, privacy, and freedom from cruel, inhuman, and degrading treatment, he has not taken this into consideration. “She knows that it is a criminal offense,” says Masinde. “If I can prove that [a woman] has been aborting, I can do [an examination] even without her consent.”

B. LACK OF ACCESS TO CONTRACEPTION: A ROOT CAUSE OF UNWANTED PREGNANCY IN UGANDA

Access to family planning services and information is central to protecting women’s and girls’ rights to life, equality and non-discrimination, information, and health, among others, guaranteed in regional and international human rights instruments ratified by Uganda.⁵¹ The CEDAW Committee has specifically expressed concern over “women’s limited access to quality reproductive and sexual health services, especially in rural areas” in Uganda⁵² and urged the government to “strengthen and expand efforts to increase knowledge of and access to affordable contraceptive methods throughout the country and ensure that women in rural areas do not face barriers in accessing family planning information and services.”⁵³

In the absence of contraceptive services, women may experience unwanted pregnancies, possibly resulting in death or illness due to lack of adequate healthcare, or they may seek out unsafe abortions that can result in injuries or death. Further, lack of contraceptive access affects women’s right to control their fertility, the right to decide whether to have children and the number and spacing of children, and the right to self-protection against sexually transmitted infections (STIs), including HIV/AIDS.⁵⁴

Yet currently the unmet need for family planning for women in Uganda stands at 40.6%: the second-highest rate of unmet need for family planning in the world.⁵⁵ This means that two out of every five Ugandan women aged 15-49, currently married or in a relationship, who want or need to delay or prevent pregnancy are not using any form of family planning. Within this 40.6%, 24.5% of Ugandan women have expressed the need for family planning to space their births, and a further 16.1% require it for limiting the number of their children.⁵⁶

Contraceptive use throughout the country is low—according to the 2011 UDHS, only 24% of all women and 30% of currently married women use some method of contraception.⁵⁷ These figures and other research indicate that seven out of ten married women of reproductive age in Uganda want to avoid or delay pregnancy, yet do not use contraception or use a traditional and less effective method.⁵⁸ According to the 2007 Uganda Service Provision Assessment Survey (USPAS), one-third of births to women between the ages of 15 and 49 were mistimed, with 13% of pregnancies unwanted at the time of conception.⁵⁹ The shortfall in family planning services means that Ugandan women on average have two more children than the number of children they desire.⁶⁰ Lack of access

to family planning also contributes to maternal deaths in Uganda by depriving women of the ability to space their children and safely space their pregnancies.⁶¹ Research indicates that meeting just half of the unmet need for contraceptives in Uganda would result in 1,600 fewer maternal deaths annually.⁶²

Access to contraception in Uganda is undermined by a number of factors, including the government’s failure to ensure sexuality education in schools, lack of access to information about and an adequate and consistent supply of contraceptives, financial barriers such as user fees, unavailability of a preferred contraceptive method, and absence of supplies necessary to insert certain methods. Some providers deny services to people they think should not be sexually active, such as unmarried girls. Other problems include poor quality and biased or discriminatory service provision, and widespread myths and misconceptions associated with contraceptive use arising from a lack of accurate information and education on family planning options. In addition, cultural and social standards that construe women as subordinate to men—violating women’s rights to equality, non-discrimination, and reproductive self-determination, particularly on matters of family planning—also undermine women’s access.

The testimonials and commentaries highlighted here capture the prevalence and serious consequences of these barriers for the lives and health of different categories of women and girls. The prevailing lack of access to family planning information and services in Uganda puts women’s lives and health at risk, giving rise to violations of their rights to health, dignity, non-discrimination, and life, among others. By recognizing these barriers, the government can develop required legal and policy reform to produce more sustainable improvements in women’s access to family planning services, and in doing so, uphold its human rights obligations.

PERSONAL TESTIMONIES

LACK OF ACCESS TO CONTRACEPTIVE INFORMATION AND SERVICES

EDITH⁶³

As a sex worker, Edith has always been critically concerned with reproductive health, even when she admittedly knew little about it. But until she enlisted the services of Reproductive Health Uganda (RHU), her life was a constant roll of the dice.

Growing up in Bwaise, a slum area of Kampala, Edith, 24, became sexually active at age 12. When she first became pregnant while still a schoolgirl, her parents kicked her out of the house. She turned to the man responsible for the pregnancy for help and he took her to obtain a clandestine and unsafe abortion from someone she believed was a doctor. “But I found one girl who [had] aborted, and she was dead on the bed. So the doctor told me, ‘You wait until we move the dead body, and then you enter.’ I started to run away,” says Edith.

She stayed with a friend until she gave birth, but then she had no way to support herself. “I wanted money to look after my kid,” says Edith. “I wanted clothes; I wanted food, shelter, things of that kind.” So she became a sex worker to provide for herself and her child.

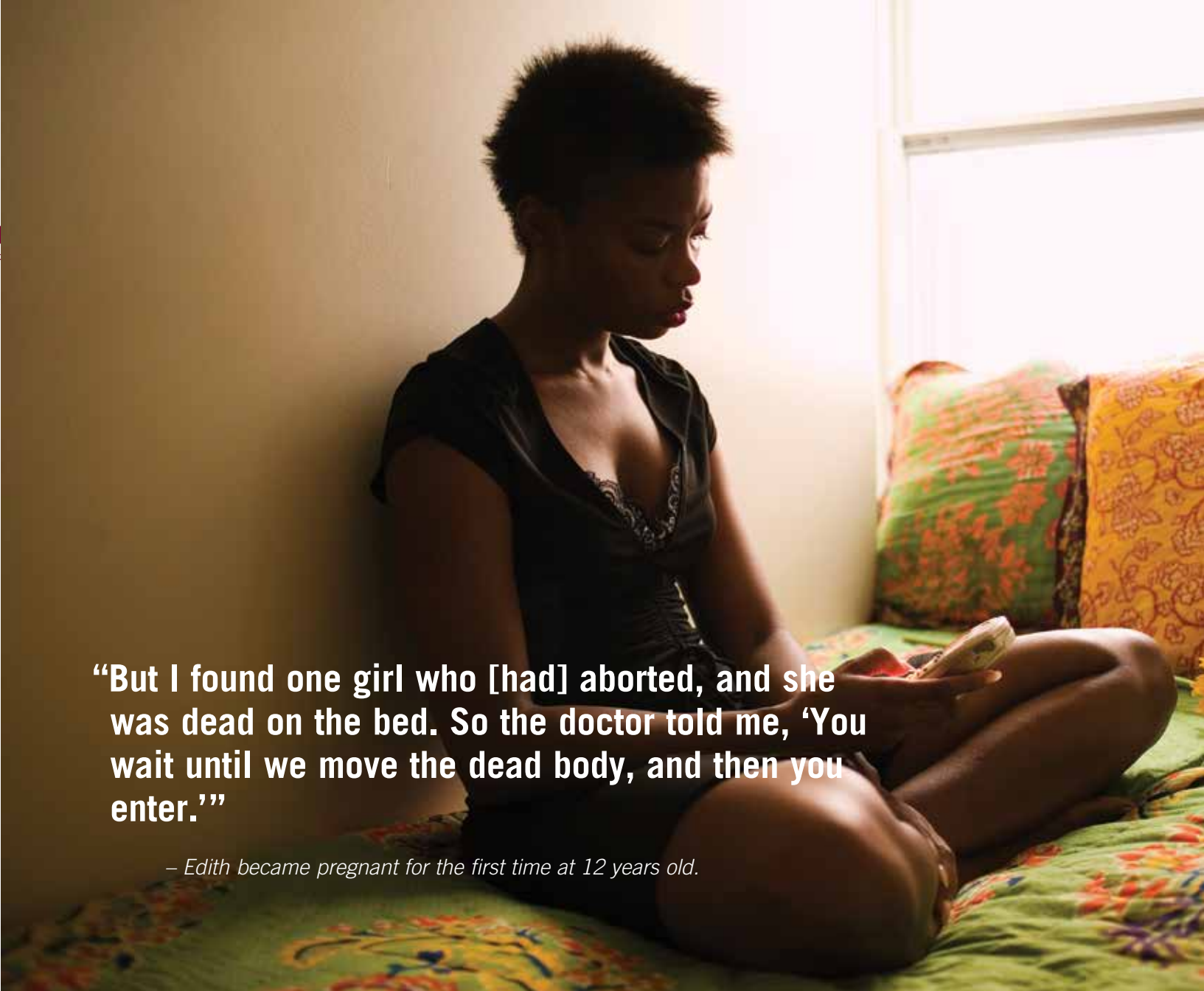
With that line of work came the added risk of pregnancy.

Edith still had no knowledge of, or information about, contraceptive services and methods. Not surprisingly, she became pregnant again, but experience had changed her perspective. “I felt very bad,” says Edith. “I said, ‘I can’t give birth to this kid. I have to abort.’”

By now, she had learned that unsafe and clandestine abortions could lead to injury or death and not having the money to secure a safe abortion, she found an elderly woman who used local herbs, a method that she could afford. But the potential consequences were not lost on her.

“I heard that it is very dangerous—I could even die,” says Edith. “I was really worried [so] I wrote a letter, and I left it with my daughter in the bed. If anyone comes, the letter which I wrote was directing the people who can help my kid to my parents. . . . I thought I was going to die.”

The elderly woman gave Edith herbs without any information about them, just the instruction to take them home. Edith went through a “very, very painful” two days before the pregnancy terminated. That is when the profuse bleeding started—two straight weeks.



“But I found one girl who [had] aborted, and she was dead on the bed. So the doctor told me, ‘You wait until we move the dead body, and then you enter.’”

– Edith became pregnant for the first time at 12 years old.

But she still had no access to family planning education or contraceptives. Several pregnancies ensued, followed by abortions. Edith took more precautions, even raising the money to obtain a safe abortion in a hospital at a cost of UGX 75,000.⁶⁴ But her life changed once she had knowledge of and access to family planning services.

Edith developed new confidence after she connected with RHU and, specifically, the Moonlight Stars Clinic, which caters to sex workers in Bwaise. Contraceptives are a part of her life now, and should they fail, Edith can quickly access emergency contraception from the clinic to prevent a pregnancy.

And she has a second child now. This one, though, was planned after she and her partner had taken HIV tests.

PERVASIVE MYTHS AND MISCONCEPTIONS
ABOUT CONTRACEPTIVE USE

NANSUBUGA⁶⁵

Nansubuga first started taking birth control pills because she and her husband already had two children and had decided not to have any more. However, in the absence of comprehensive evidence-based family planning information, she later succumbed to a common misperception about contraception: “I stopped because in the community, we have this thought that once you have taken family planning for so long, you can’t get pregnant again. So I just thought like that.”

Soon after going off the pill, Nansubuga became pregnant, thus refuting the myth, and was forced by her husband to have an abortion. “I was just told,” she says. “It wasn’t my decision. He told me, ‘Go and terminate it!’ So I went. I followed his instructions.”

Nansubuga went to a clinic that she had learned was willing to perform clandestine—and unsafe—abortions. She paid UGX 100,000.⁶⁶ The provider tied down her legs before starting a procedure that caused excruciating pain. Although she cried, the provider simply said, “You came here to terminate it.”

A month after the abortion, Nansubuga became pregnant again. Her husband pushed her to get another abortion, but this time Nansubuga refused. The memory of her recent procedure convinced her never to undergo another clandestine abortion. She had also heard that clandestine abortions were usually unsafe and could lead to death or serious injuries. After her third child, Nansubuga went on to have three more children. She now takes birth control injections, although she laments that the neighborhood clinic does not provide advice or information, and the people who run it are inexperienced.

Nansubuga believes that the community needs to be better educated about family planning services, and that safe abortions should be available to the women of Uganda. She advocates that women should not be forced to make reproductive decisions they do not want to make, that laws should permit safe abortions, and that abortions should be offered free of charge at health clinics. “[L]et them reduce the charges to avoid maternal death. Let the prices be removed so that it is open freely. We are losing very many mothers. . . .”

JOYCE⁶⁷

When Joyce’s husband found out she was using birth control pills, he beat her ruthlessly because of his misconception about contraceptive use.

“He didn’t want me to take the pills because [he said] they destroy a woman’s reproductive health,” says Joyce. “[He said they] also destroy their sexual urge. That’s what he told me and he gave me a thorough beating. He beat me very badly; all of my body was swollen.”

Joyce, 33, has five children today; the youngest is five, the oldest 17. She married when she was only 15. Relying on natural methods of family planning, she had her first child shortly after the marriage. “We were living in the village. And in the village there are no decisions made by women, the control is by men,” says Joyce. “If the man wants to have children, you have them. You are doing what everyone else is doing. What helped me is when we moved from the village to town, my friend the nurse started telling me about family planning, and that has opened my eyes.”

After having four children in quick succession, Joyce began taking birth control pills provided by her friend, who also gave her help with instructions. Joyce successfully used the pills for six years. Then her husband found out.

After she reported him for the beating, Joyce’s husband ran away, leaving her to care for their children. But having control of her reproductive health has helped her to take care of her children. “The good thing with family planning is that it enables you to take care of the family,” says Joyce. “The children are in my care but I am able to take care of them. If I was pregnant right now, and had a small baby, I wouldn’t be able to go out and look for money to take care of myself and the children.”

Many women in Uganda would be better off if they had access to contraceptives, as Joyce did. “Women who don’t use family planning lose a lot of opportunities,” she says. “For example, I have a friend of mine who has a very young baby of six months, and right now she is expecting. She has a baby of two years, a baby of one year, a baby of six months, and she is expecting. The man doesn’t assist her to maintain these children. At home she is in poverty, and in need of basic requirements. She doesn’t look healthy. She is not happy.”

DENIAL OF ACCESS TO CONTRACEPTIVES DUE TO NEGATIVE PROVIDER ATTITUDES AND FEAR OF UNPLANNED PREGNANCY

DIANA⁶⁸

Diana, 21, was born with HIV. Only when she grew older did she learn that the medications she had been taking since she was four were antiretroviral medications, and not for pneumonia.

Diana's partner was also born with HIV. They buy and use condoms together to prevent pregnancy, though obtaining them can be either expensive or a painful encounter with discrimination. "Getting contraception is quite hard," she says. "In some [private] clinics you have to buy them. In government facilities, you don't have to buy them, but where the challenge comes from is the unfriendly challenges you find in the health facilities. If you go there, you may find people saying, 'As young as you are, you are getting these contraceptives. Why? Your parents pay school fees for you to study.'"

Sometimes Diana will reveal her medical condition to the health care worker, in hopes that she might avoid such confrontations, but that does not always work. "They say, 'But you people are HIV positive, and you don't even think about your health, why don't you leave things like having sex to others. You are HIV positive. You should not have a partner in life.'"

Yet despite the health risks that living with HIV can bring, the condition that brings the greatest fear is unplanned pregnancy. Diana has several friends who have sought out unsafe abortions due to unplanned pregnancies. One young woman had her fourth abortion and almost died. A second friend had an unsafe abortion at 14. She asked for help from a traditional birth attendant, who provided her with an herbal mixture. The results were nearly catastrophic, as she ended up in the hospital. Soon after, her mother pulled her out of school. Tragically, another young woman who was too ashamed to tell her parents locked herself in her bedroom to self-administer an unsafe abortion, while giving the impression that she was out of town for a few days. After more than a week, a smell began to emanate from the room. The young woman had died in a pool of her own blood.



"They say, [the health care workers] 'But you people are HIV positive, and you don't even think about your health, why don't you leave things like having sex to others. You are HIV positive. You should not have a partner in life.'"

– Diana, she and her partner were born with HIV.

The source of this fear is no mystery. "They are so scared of pregnancies," says Diana. "'As long as I don't get pregnant' is what they say. But they rarely say, 'As long as I don't get an STD, or HIV. . . .They fear their parents because some of them are school-going, and their parents will say, 'You get pregnant, I will kill you or send you away from my home.'"

PERSPECTIVES FROM KEY STAKEHOLDERS

DISCRIMINATORY CULTURAL AND SOCIAL STANDARDS REGARDING WOMEN’S EQUALITY AND AUTONOMY

ANNET⁶⁹

Annet is a volunteer at a local clinic in Kampala, where she teaches about family planning and distributes condoms. In Annet’s ideal world, the only women who get pregnant are the ones who want children. Women who do not want to have children, or are not ready, need access to contraceptives, she says: “They should use family planning so they don’t get pregnant.”

Having come into contact with thousands of women in need of family planning services, she is aware that it is not always so simple. Observing the experiences of the women around her, Annet describes how factors relating to family planning impact a woman’s life and health.

Uganda’s human rights obligations require it to eliminate discrimination against women in matters relating to marriage and family relations, and ensure they have equal rights to freely and responsibly decide the number, timing, and spacing of their children.⁷⁰ Yet women in Uganda do not always have control over whether they get pregnant. **It’s difficult to tell a man to wear a condom, especially if that man is your husband,” says Annet. “When he refuses, there’s no way I force him to wear it.** How can a man buy for you food when you have denied to give him sex? It is very difficult to deny your husband sex, because he is entitled, and if you refuse, he has a right to ask you to leave the home.”

The failure to eliminate these violations of women’s rights, including their right to reproductive self-determination, dignity, and non-discrimination, makes unplanned and unwanted pregnancies inevitable. Further, widespread lack of information about the content of Uganda’s abortion law and what it permits forces incredibly difficult decisions upon women. Fear of imprisonment drives the behavior of women and physicians. Doctors who perform abortions in secret make decisions to protect themselves, which include staying in hidden and ill-equipped locations with unsanitary conditions and not attending to women who develop complications due to the poor conditions.

Annet has seen this firsthand. “The clinic people normally tell these girls to make an agreement that if anything goes wrong they shouldn’t go back to the clinic, so they try to go somewhere else to get assistance,” says Annet, “but if everything



There was “this girl who had an [unsafe and clandestine] abortion and went back to the doctor and said she was feeling pain. He refused to attend to her. When she died, the doctor bundled up the body of the deceased and dumped it in a pit latrine.”

Annet, a volunteer at a local clinic in Kampala, where she teaches about family planning.

fails, then they lose their lives.” One girl Annet knew lost her life as a result of a clandestine and unsafe abortion. In death, she also lost her dignity as a result of the doctor’s fear of being caught.

There was “this girl who had an [unsafe and clandestine] abortion and went back to the doctor and said she was feeling pain,” says Annet. “He refused to attend to her. When she died, the doctor bundled up the body of the deceased and dumped it in a pit latrine.”

DEUS KIWANUKA⁷¹

The power imbalance between men and women in Uganda exists in every aspect of life, says Deus Kiwanuka, a senior program officer at the Center for Domestic Violence Prevention. He is not speaking only from professional experience.

“I have seen my mother going through this abusive life,” says Kiwanuka. “I have always been touched by the life that my mother lived. I am the last child in my family, and I have seen my own sisters suffering in very abusive relationships. . . . So when I am talking about these issues, I am not imagining, I am not telling stories, I am not thinking about theories, I am out there talking about something I have gone through myself.”

Kiwanuka’s work addressing violence against women and young girls, including HIV-related violence, has expanded his perspective. “The root cause of violence against women is basically the imbalance in power within intimate relationships,” he says. “And this has been socially constructed and seen as acceptable in our communities. It has been embedded within our institutions, within our cultures, within the legal framework.”

One critical consequence is discrimination in health care facilities. Often, facilities will wrongly require spousal consent before dispensing reproductive health care to women. This practice is at odds with the legal and policy framework in Uganda—there is no law, policy, or regulation in Uganda compelling women to obtain consent from their spouses before they can obtain reproductive health services. In fact, the Reproductive Health Guidelines explicitly state that spousal consent is not required for family planning services.⁷² The practice also violates women’s fundamental human rights to health, self-determination, and autonomy. “A woman will not even be able to access reproductive health services without the permission of her husband,” says Kiwanuka. “Where will you go? When you go to hospitals, when you go to a health center, [a woman] realize[s] that up to now in Uganda, many of these service centers will require you [to obtain] permission from your spouse—and that’s the man—to receive these services.”

When it comes to having children, men expect to make the decisions. “There is a local saying in Uganda,” says Kiwanuka. **“You will have these children until you have no more in your womb because I paid for you.”**

An inadequate health care system only exacerbates this inequality. Poor quality of service and discrimination by providers results in denial of services, another reason for inadequate family planning access for women and adolescent girls. “The quality of the service they give is also horrible,” says Kiwanuka. Women are asked to produce permission for birth control even though such a requirement is both discriminatory and not in accordance with any law in Uganda. “If you are not married, if you are not in a consensual relationship, then you are not expected to use those services. They ask, ‘Why are you engaged in sex? It is for the married people.’” He adds, “No one will punish health care worker[s] for denying medicine. People will say, ‘Why was she looking for contraception?’”

The poor quality, or complete absence, of sexuality education in schools aggravates these problems. “Sex is taught with a lot of fear, taught with sugar coating, hiding,” says Kiwanuka. And it does not happen at home, either. “There is no talk between parents and children on sexual issues.”

All of these conditions factor into the country’s maternal mortality problems. Without sexuality education and accurate family planning information, people are unaware of how they can control the timing of pregnancy. When health professionals deny services to sexually active women, many are bound to become pregnant and some resort to unsafe abortion and die. Providing sexuality education and family planning information and services to all who need it, and expanding access to safe and legal abortion would represent a huge step toward reducing maternal mortality, though some of the attitudinal problems are deeply ingrained among the people and pose a remaining hurdle. As Kiwanuka explains: “Even though you [pass] a law, [you must work on] those stereotypes of the people.”



Women living with HIV should have access to safe, legal abortions, but rarely do.

– Dora Musigunzi, Executive Director of the Uganda Network.

DORA MUSINGUZI⁷³

The question is straightforward: Can a woman who wants to use family planning methods do so if her husband does not want her to? The answer, regrettably, is even more direct. “No, she has to ask for permission,” says Dora Musinguzi, executive director of the Uganda Network on Law, Ethics & HIV/AIDS (UGANET). “They have to always ask their partner.” Though the Reproductive Health Guidelines state that spousal consent is not required for family planning services,⁷⁴ this discriminatory practice persists due to the continued existence of sociocultural norms that the government is mandated to eradicate as part of its human rights obligations.

Another major problem she describes is the discrimination women living with HIV encounter. Musinguzi and UGANET provide advocacy and legal services to people living with HIV/AIDS. Women living with HIV should have access to safe, legal abortions, but rarely do. And nearly half of pregnant women living with HIV and who would like to continue the pregnancy do not have access to the medicines necessary to prevent vertical transmission. There are many reasons for these failures of healthcare, and one of the most disturbing is the negative attitude of health care providers toward these women, which Musinguzi describes as “an established practice.”

Barriers to accessing family planning services and abortion are felt most sharply by the most vulnerable of women, according to Musinguzi.

AGNES⁷⁵

Agnes, who works with an NGO that is on the front lines addressing gender-based violence through trainings and awareness campaigns, notes that preventing an unwanted pregnancy is not a simple or easy matter for women. While her NGO encourages both women and men to discuss family planning and attend educational sessions about family planning options, many men refuse. Women must overcome the reactions of their families and communities, and often must resort to accessing family planning services secretly.

Women in Uganda often experience similar reactions when trying to introduce their husbands to family planning. “This woman will say, ‘But if I go on contraceptives, he will go out and get kids elsewhere.’ That then makes them fear going for contraceptives and going to the clinic,” says Agnes.

Women also fear stigma in their communities if it becomes widely known that they are using condoms or other forms of contraception. **Women exercising control over their own reproductive choices are often suspected of being unfaithful to their husbands or engaging in other illicit activities.** These gender-based cultural barriers to access remain despite the government’s obligation to eliminate them through comprehensive and evidence-based information on family planning.

Moreover, hypocrisy over contraception is the norm in Uganda. “A girl having a condom is immoral,” says Agnes. “A guy having a condom is fine.”

GOVERNMENT’S FAILURE TO PROVIDE ADEQUATE AND ACCURATE FAMILY PLANNING INFORMATION AND ESTABLISH SEXUALITY EDUCATION IN SCHOOLS

DR. MILTON AWUDO⁷⁶

Performing a Cesarean section on a 13-year-old girl can truly reveal the inadequacies of a government’s policies on sexuality education and reproductive health care. Dr. Milton Awudo has seen just how little an adolescent girl can know.

“Most likely she didn’t even know she was pregnant,” says Dr. Awudo, head of clinical services at Marie Stopes in Uganda, where he works tirelessly to provide women with reproductive health services, including family planning services. “You tell her ‘you’re pregnant, you have to go to antenatal,’ [but] she doesn’t know what it means.”

The lack of sexuality education is an enormous problem in Uganda. “The latest research show that 96% of people in Uganda know there is something called family planning, but the details of what this means, they do not know,” says Dr. Awudo.

But even if information flowed freely, the country would still have a massive problem with access. “In our country, the perception is that family planning is for women—because apart from vasectomy and condoms, all the methods are for women.”

In Dr. Awudo’s experience, women clearly want contraception. At his clinic and through outreach, he tries to get women the health care that they need, but sometimes he gets to them too late. A pregnancy test is required before giving a woman any kind of family planning services, and women often break down when they discover they are pregnant just as they are about to get the contraception they needed. Although the law on termination of pregnancy contains a life and mental and physical health exception, Dr. Awudo believes that the law contains only a life exception and that he is not allowed to offer anything further to the women. But he says that this does not mean that women will not find other avenues to abortion.

“What I have seen in all my years of practicing, if a woman does not want a pregnancy, she will do it whether the law is there or not there,” says Dr. Awudo. “She will do it and she may not come back to you because you did not

help her before.” She will not come back even when she desperately needs help. He has not performed an abortion, even to save a pregnant woman’s life, because he thinks the threshold for meeting the abortion law’s life exception is unclear, although the Ministry of Health’s Reproductive Health Guidelines provide clear guidance on how to interpret this exception.⁷⁷ “That condition is difficult,” says Dr. Awudo. “By the time you decide it is endangering the life of the mother, maybe it is too late.”

According to him, the government must not only change the law but also train providers and equip health facilities to improve access to safe abortions. These changes must also be accompanied by government efforts to eliminate discrimination against women and ensure they enjoy full access to all human rights guarantees. And, of course, all services must be affordable and accessible.

SOLOMY⁷⁸

The barrier blocking access to family planning information that Ugandan women struggle against is twofold: the government not only fails to deliver proper and adequate information about contraceptive use, but also much of the information that does circulate is grossly false.

“Most women still fear [using contraception due to misconceptions],” says Solomy, a community trainer on health issues for women living with HIV. “Someone will say, ‘Ah, you’re going to go for family planning? It will burn all your eggs. You won’t conceive again.’ Or, ‘Ah, those things [medications], they won’t work here in Uganda. They cannot work here.’ Then others will say, ‘Ah, when my husband says that he wants to stop, I will stop.’ So, those are some of the things that are limiting people mostly from getting reproductive health.”

Family planning does far more than protect women from having an unwanted pregnancy. Its benefits are long lasting and vital to their family’s well-being. “It helps you build a bond between your child and you, and at least try to balance the home and the relationship with your husband and each other,” says Solomy. “It looks simple, but in real life, it’s not. I believe in family planning because it helps the body, it helps bond with the child—that means

the child grows up knowing that she’s loved. I’ve seen kids, this one is one year old, one year and a half, and you give birth to another kid, and I’ve been able to notice how the relationship is. This one is crying, thinking maybe that someone has taken their [mother’s] attention, and she is crying, and this one is complaining, and this other one has to go to school, but there is no one to organize her, and no one is paying attention.”

Solomy has one child herself, a one-year-old. She says she plans to wait three years to have more children, and is using condoms with her husband.

HONOURABLE MONICAH AMODING⁷⁹

Ugandans face the same obstacle to effective family planning shared by women around the world: It costs a lot of money. But there are other factors at work in Uganda, born out of the lack of information and knowledge. “You cannot tell the girls below 18, or even below 24, to use certain contraceptives,” says the Honourable Monicah Amoding, a Member of Parliament. “They believe they are harmful to their reproductive systems; that in the long run, after consistent use, they will fail to have children.”

Such misconceptions are not restricted to the young. “There are so many myths, even amongst [older women who use contraceptives]. We have so many fears that have not been dealt with.” She adds: “Others think [contraceptives] are cancerous.... Because in Africa there is a lot of cancerous diseases and you are wondering where they are coming from.”

Getting women to understand and accept contraception is crucial to both their well-being and their dignity and equality.

“Private life and the personal rights of women are still very highly contested. You find that the right to have or not to have a child is still very much controlled by the State,” says Amoding. “If I cannot control that area of motherhood and provide safe maternity services, then I cannot be a complete person in the public arena.”

HONOURABLE SYLVIA SSENABULYA⁸⁰

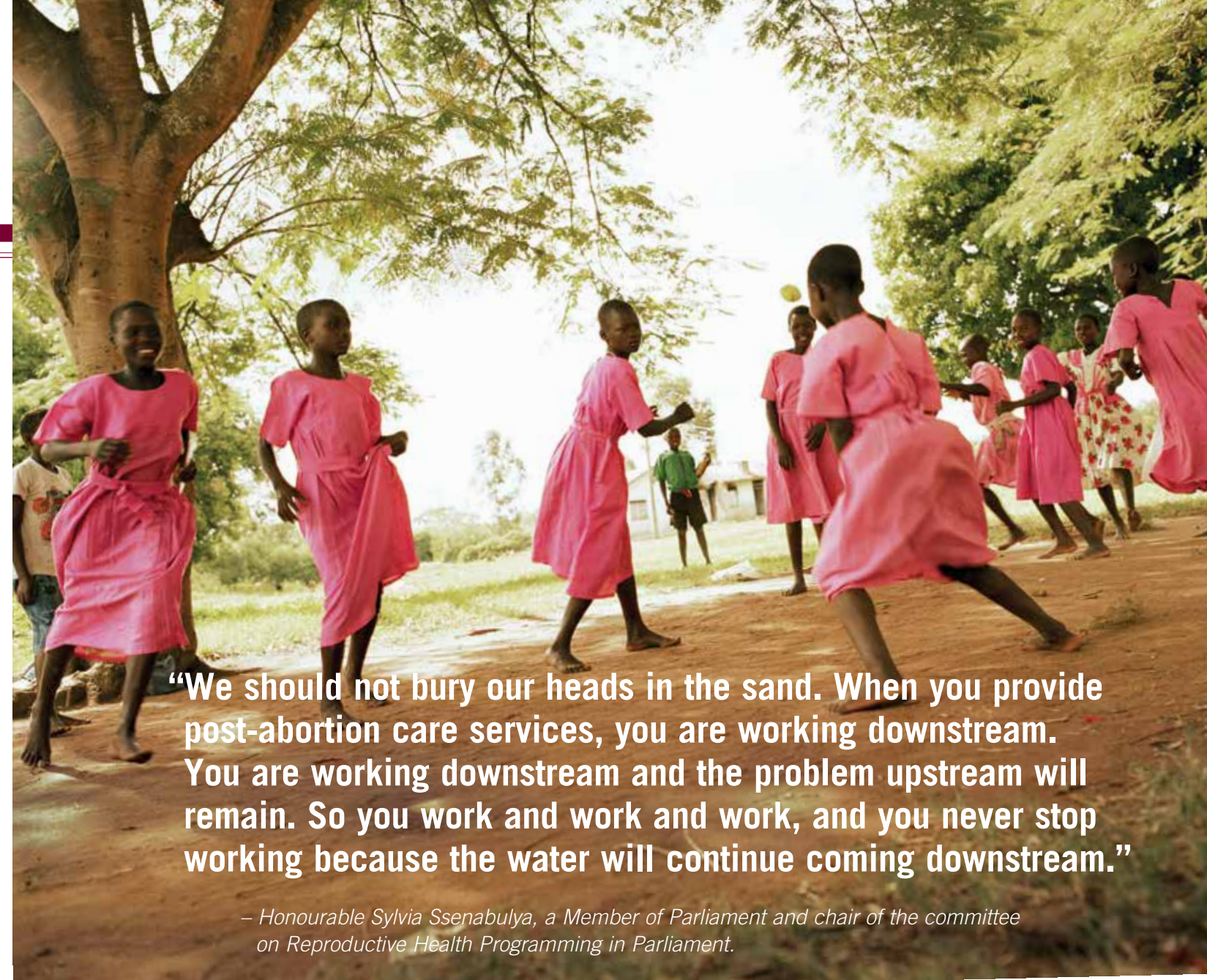
The Honourable Sylvia Ssenabulya, a Member of Parliament, chairs the committee on Reproductive Health Programming in Parliament. She serves as a strong advocate for women’s reproductive rights in a country that suffers from a high incidence of clandestine abortion and sees little chance of government intervention to fix the problem. Family planning education needs improvement, access to services must expand, and the government needs to redirect its attention away from just PAC and toward such preventative care as improved access to safe and legal abortion so that women will not needlessly die.

The lack of accurate information about and access to contraceptives prevents women and men from engaging in family planning activities. “There are many women who would think ‘maybe I should space,’ says Ssenabulya. “I believe even all women who want to have children, they don’t want to have them year in and year out, but then the lack of information surrounding family planning and contraception also now comes in and [the women say] ‘maybe if I take it [contraception], maybe I’ll become sterile, maybe I’ll bleed, maybe I’ll develop cancers, etc.’”

Too often women find something preventing them from using contraception. “You find that either the woman wants to [use] contracept[ion], but the service is not available,” says Ssenabulya. Or “The service may be available but it’s not the right product mix. She may even try a particular product or a particular method and it doesn’t work for her. But because maybe she’s not informed she may think it’s like that for all methods. Or she may get discouraged altogether, and of course there may be no person around her to give her the right advice.”

While the provision of PAC is necessary, it does not address the key problem: the high incidence of preventable maternal deaths from unsafe abortions is brought on by the lack of clarity in Uganda’s abortion law, leading to the mistaken perception that abortion is illegal except to save the life of the woman.

“We should not bury our heads in the sand,” says Ssenabulya. “When you provide post-abortion care services, you are working downstream. You are working downstream and the problem upstream will remain. So you work and work and work, and you never stop working because the water will continue coming downstream. You mop and you mop and mop until one time you cannot do it. So, we need to work upstream and address the issues that bring about unsafe abortion.”



“We should not bury our heads in the sand. When you provide post-abortion care services, you are working downstream. You are working downstream and the problem upstream will remain. So you work and work and work, and you never stop working because the water will continue coming downstream.”

– Honourable Sylvia Ssenabulya, a Member of Parliament and chair of the committee on Reproductive Health Programming in Parliament.

Ultimately, Ssenabulya emphasizes the need to respect women’s choice and establish access to safe abortions.

“I think we need to give women choices,” she says. “If someone else wants to have an abortion, it’s a personal choice. It’s a personal choice, why should I legislate against it, because I don’t. It’s something within that person. She adds: “If she says, ‘No, I don’t want it,’ then let her have a choice. It’s a personal choice.”



INADEQUATE ACCESS TO CONTRACEPTIVES RESULTING FROM HIGH COSTS AND STOCK-OUTS

IRENE⁸¹

Irene's job as a midwife in Mubende includes counseling patients about family planning. "I can just tell them to space their children, but for me I don't do family planning here because I don't have the medicine, but I can give them advice to space their children," she says. Irene advises her patients about the financial difficulties of supporting too many children in Uganda, and also about the harmful impact of poor child spacing on women's health.

She refers women to public hospitals to obtain contraceptives, but says there are often stock-outs. The women do not complain, she says, "[T]hey just keep quiet." Ugandan health policies seem to ignore preventative care options and instead focus on managing the consequences of poor reproductive health care services. "[Hospitals] only work on those who are already in the process of aborting," she says.

Even though reproductive health care is her profession, Irene remains unclear about the grounds for a lawful abortion.

Irene would like to see the law clarified to practitioners so that they can perform the procedure safely and legally. "I would appreciate guidelines because there I would know what my limits are."

ANNA⁸²

Sexually active women who cannot access contraception are unable to control when they get pregnant, sometimes to their detriment. When women cannot space their children properly, serious complications arise. Anna, a member of Uganda Private Midwives Association, has seen the consequences of lack of adequate spacing firsthand.

"A mother's uterus gets weaker and then it might fail to contract after delivery and the mother gets [postpartum hemorrhage]," she says. "Then there is the malnutrition because when these children [are many] it is difficult caring for them and you find these children get malnourished. Even the mothers get malnourished."

The risks for adolescent girls are even higher. "Those girls at that age, their bones are not yet well developed," says Anna, "so when they get pregnant they are the ones that get [cephalopelvic] disproportion.⁸³ That's when they get obstructed labor."

These are not big concerns for men, according to Anna. They do not care about using contraceptive methods since the women are the ones who get pregnant, deliver the children, and care for them.

Anna has seen just how desperate women can be to avoid another pregnancy. "I have attended to a lady who took a piece of wood and inserted it in her vagina to terminate the pregnancy," says Anna. "The piece of wood stayed there for about five days because she was determined that the thing should come out because she didn't want the pregnancy. It was rotting inside of her. She came in with high fever. Only during examining her did we find the piece of wood was inside."

The only solution is to expand the grounds for safe and legal abortion. "It will help to reduce the maternal mortality rate because even young girls are dying," says Anna. "They are dying from unsafe abortions."

Sexually active women who cannot access contraception are unable to control when they get pregnant, sometimes to their detriment. The risks for adolescent girls are even higher. "[A]t that age, their bones are not yet well developed."

— Anna, a Member of the Uganda Private Midwives Association.



LACK OF GOVERNMENT’S LEADERSHIP ROLE IN COORDINATED AND SUSTAINABLE PROVISION OF CONTRACEPTIVE SERVICES

MS. ZAAMU KABONEKE⁸⁴

Uganda has one of the highest fertility rates in the world. Given the country’s other problems, it’s a characteristic of the country that is very difficult to change, and very much part of its culture. “The general feeling in the community is that they can’t control the number of children in their families because of conditions beyond their control,” says Zaamu Kaboneke, a lawyer associated with LAWA.

Signs of progress are evident, however minor they might be. Girls are going further in their education, and this is helping shape new reproductive realities. “A girl who was dropping out at 13 years, now will not drop out. She will go to university,” says Kaboneke. “You have to find a job and you have to become independent. When will you have time to have a baby?”

And Ugandans have certainly become more aware of condom use because of the rise of HIV/AIDS. Couples are thinking more about the consequences of sex, says Kaboneke, realizing they need to “protect each other.”

HIV has taken its toll on Uganda’s families, even those who have avoided illness, because of all the children whose parents have died. Even couples that have managed to plan their family well still wind up supporting many children. “I only have three children,” says Kaboneke. “But you will never find less than ten children under my care. They are not my biological children, but I treat them as my own. I feed them. I pay school fees. I clothe them. And I imagine many other families in the country are going through the same.”

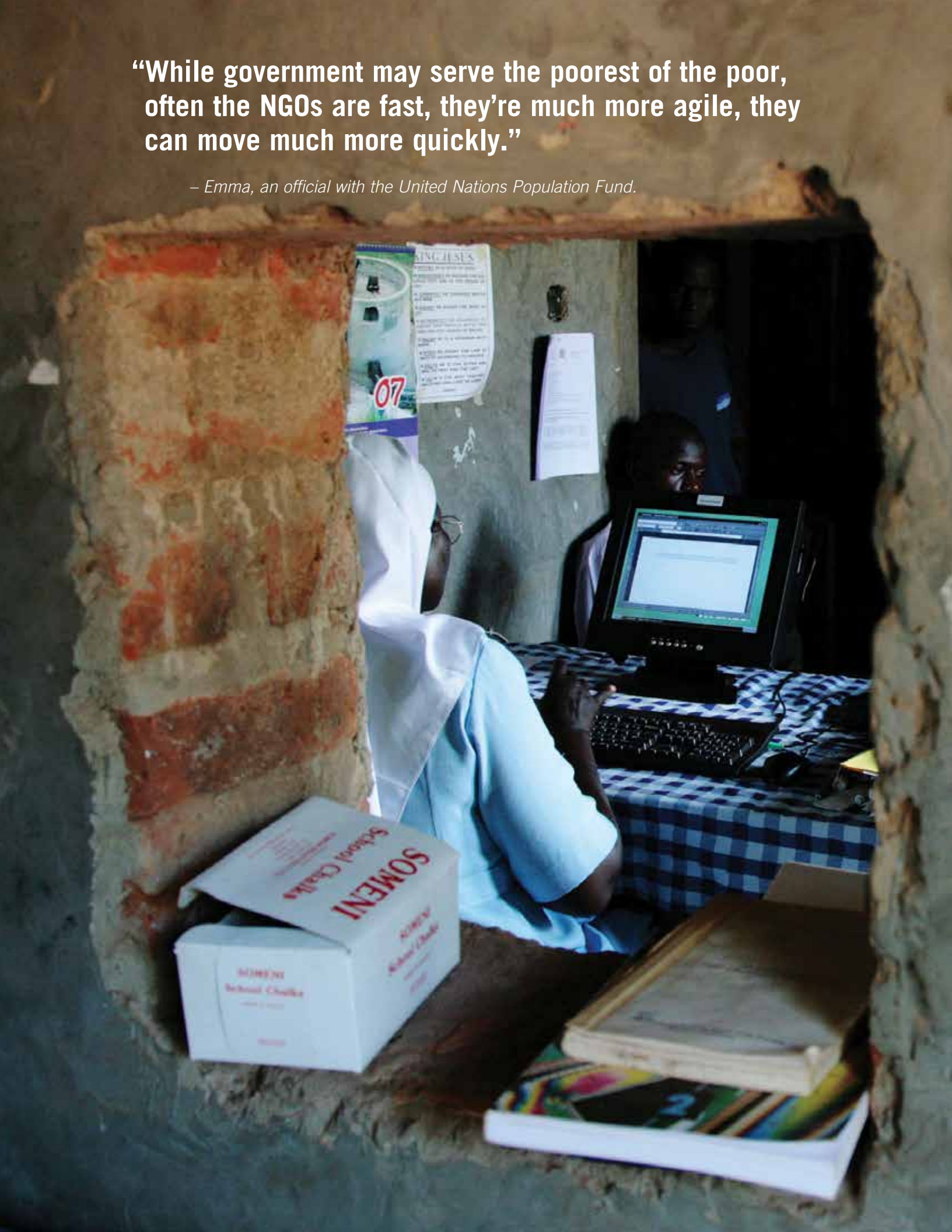
In some cases, the result is a cycle of poverty that is difficult to escape, resulting in the breakdown of the family and making it especially difficult for adolescent girls. Desperate to avoid causing any more problems for their family, they seek out illegal, unsafe abortions. “Your father sent you to school. Are you going to go back to your father and say, ‘Daddy, I’m pregnant, can I have an abortion?’” says Kaboneke. “Very few daughters would do that. They would rather take the risk [and avoid] the shame to the family that you have gotten pregnant out of wedlock. They will brand you as a prostitute.”



So unsafe abortion endures. “Once something is illegal, doesn’t mean it stops happening,” says Kaboneke. “Abortion is not something people talk about openly. It is like prostitution. You hear about it but you don’t see it.”

“While government may serve the poorest of the poor, often the NGOs are fast, they’re much more agile, they can move much more quickly.”

– Emma, an official with the United Nations Population Fund.



EMMA⁸⁵
One perspective from Uganda’s current reproductive rights landscape is that the country is ripe for progress. “Uganda has one of the highest unmet needs for family planning [in Africa],” says Emma, an official with the United Nations Population Fund.

“[But] the contraceptive prevalence rate has risen from 18 percent to about 22–23 percent in the latest DHS [Demographic and Health Survey] report, which shows that it’s going up. It’s perhaps a bit slower than we anticipated, but I think that the fact that it’s going up shows that there’s real potential for transformation here.”

But the government needs to step into a bigger role. Emma observes that NGO-run private facilities provide contraception more widely and reliably than the government centers. “The fact that women want contraception and need to access it is important,” she says. “We can also see that the majority of women get their contraception through the NGO sector, so that’s another powerful argument that while government may serve the poorest of the poor, often the NGOs also have a huge role in breaking through this demand gap and reach the women. They’re fast, they’re much more agile, they can move much more quickly.”

However, the need for the government to take the leadership role in providing contraceptive services is clear. “We place an emphasis on systems building and the role of the Ministry in terms of regulation, so that’s very important for us. So it’s important that we have a coordinated, streamlined effort, and that we have synergies between what we all do.”

NGOs and the government can certainly work together. “NGOs and the not-for-profit sector, they’re here to stay,” says Emma. “The ultimate goal is not necessarily for the government to overtake that. What we want is a clear definition of roles, and the government in Uganda is a service-providing government, so there are services to be provided and [and the government has] to continue to set the policies and protocols on which people have to abide.”

“The ultimate goal for us is to see the government own the reproductive commodities agenda. At the moment, the government supports less than 5%, the rest is provided by us, but that is changing now. So for us, in terms of making [contraception] accessible, it’s important for them to invest beyond that.”

RECOMMENDATIONS

The government of Uganda’s obligations under international and regional human rights law require it to undertake immediate measures to ensure improved access to safe and legal abortion, reduce unsafe abortion, and ensure adequate access to family planning information and services.⁸⁶ Implementing the following recommendations which are primarily based on the testimonials in this report will constitute important steps toward fulfilling these obligations.

- **Publicize the current version of the National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights and widely disseminate information about the existing exceptions to the ban on termination of pregnancy. This will give clarity to healthcare providers, law enforcement, the judiciary, and women about when termination of pregnancy can be safely and lawfully accessed under Ugandan law.**
- **Address the stigma, discrimination, and silence that force women and girls to resort to unsafe abortions. Improve data collection on the incidence of unsafe abortion among adolescent girls to better understand and respond to the causes. These measures will reduce women and girls’ exposure to unnecessary risks and preventable death.**
- **Provide sensitization trainings to healthcare staff so that women with abortion related complications will know that they can get the necessary medical care without fear of hostility or inadequate quality of care and equip facilities with the necessary equipment so the staff can provide the care these women need.**
- **Ensure adequate access to family planning information and sufficient and consistent supplies of a full range of contraceptive methods to avoid stock-outs. Eliminate the financial barriers that prevent women and adolescent girls of all socioeconomic classes from accessing modern contraceptive methods.**

- **Ensure that sociocultural norms that result in barriers to access, such as the practices of requiring spousal authorization or being married as a precondition for access to contraception, do not hinder women’s right to use family planning services. Publicize the Reproductive Health Guidelines’ position that spousal consent is not a requirement for family planning services and that contraception is available to every sexually active individual. Monitor the practices and policies in health facilities to ensure compliance, and develop programs to eliminate discriminatory yet commonly held ideas that women must be subordinate to men and have no right to control their own bodies.**
- **Improve awareness about and the availability of emergency contraception for anyone who is at risk of an unplanned and unwanted pregnancy, particularly for victims of sexual violence (including marital rape), to reduce unplanned pregnancies and unsafe abortion.**
- **Embark on a nationwide informational and educational campaign aimed at both men and women to provide accurate, evidence-based information about contraception. This will help to eliminate misinformation and raise awareness about how lack of family planning can lead to unwanted pregnancy, unsafe abortion, and death.**
- **Improve access to comprehensive sexuality education for adolescents by establishing it as a mandatory subject in primary and secondary schools. Ensure that it is taught by teachers who are well-trained in this subject.**

ENDNOTES

¹ Susheela Singh et al., *The Incidence of Induced Abortion in Uganda*, 31(4) INT’L FAM. PLAN. PERSPS. 183, 188 (2005).

² World Health Organization (WHO), Sexual and reproductive health, *Preventing Unsafe Abortion*, http://www.who.int/reproductivehealth/topics/unsafe_abortion/hrpwork/en/index.html (last visited Apr. 10, 2013).

³ Singh, *supra* note 1, at 183, 188.

⁴ SUSHEELA SINGH ET AL., UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA: CAUSES AND CONSEQUENCES 4, 6, 10 (Guttmacher Institute, 2006), *available at* <http://www.guttmacher.org/pubs/2006/11/27/UgandaUPIA.pdf> [hereinafter UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA].

⁵ *Id.* at 5.

⁶ Hon. Dr. Stephen Mallinga & Anthony Mbonye, *Maternal Morbidity and Mortality in Uganda* 5 (Dec. 8–9, 2008) (*submission to ALL-PARTY PARL. GROUP ON POP., DEV. & REPRO. HLTH.–U.K.*).

⁷ *The Technical Guide* forms part of a tool kit assembled to address access to safe and legal abortion in Uganda. The tool kit is available on the Center for Reproductive Rights’ website at <http://reproductiverights.org/en/document/understanding-the-legal-and-policy-framework-on-abortion-in-uganda>.

⁸ CENTER FOR REPRODUCTIVE RIGHTS, BRIEFING PAPER: A TECHNICAL GUIDE TO UNDERSTANDING THE LEGAL AND POLICY FRAMEWORK ON TERMINATION OF PREGNANCY IN UGANDA 6 (2012) [hereinafter TECHNICAL GUIDE (2012)].

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Id.*

¹² *Id.* at 16, 23–27.

¹³ MINISTRY OF HEALTH (UGANDA), REPRODUCTIVE HEALTH DIVISION, NATIONAL POLICY GUIDELINES AND SERVICE STANDARDS FOR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS 45 (2006) [hereinafter MOH, NAT’L POLICY GUIDELINES & SERVICE STANDARDS (2006)]. The 2006 Guidelines have been recently revised. The authors were unable to obtain a copy but received confirmation from authoritative sources, including an interviewee—a senior medical officer in the Reproductive Health Division of the Ministry of Health—who was instrumental in developing the Guidelines, that the abortion-related provisions were not changed.

¹⁴ *Id.*; TECHNICAL GUIDE (2012), *supra* note 8, at 35–36.

¹⁵ Center for Reproductive Rights, *10 Key Points About Uganda’s Laws and Policies on Termination of Pregnancy* (2012), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/crr_uganda_10keypoints_v5.pdf [hereinafter *10 Key Points – Uganda*]; TECHNICAL GUIDE (2012), *supra* note 8, at 36.

¹⁶ *See* Interview with Dr. Collins Tusingwire, Senior Medical Officer, Reproductive Health Division, at the Ministry of Health, in Uganda (Mar. 6, 2012) (on file with the Center for Reproductive Rights); Interview with Dr. Andrew (name has been changed), doctor at Mulago Hospital (Mar. 6, 2012) (on file with the Center for Reproductive Rights).

¹⁷ *See* Interview with Dr. Andrew, *supra* note 16.

¹⁸ ELENA PRADA ET AL., ABORTION AND POSTABORTION CARE IN UGANDA: A REPORT FROM HEALTH CARE PROFESSIONALS AND HEALTH FACILITIES OCCASIONAL REPORT No. 17, 5 (Guttmacher Institute, 2005), *available at* <http://www.guttmacher.org/pubs/2005/05/28/or17.pdf> [hereinafter ABORTION & POSTABORTION CARE IN UGANDA].

¹⁹ *See* Interview with Deus Kiwanya, Director SASA!, Center for Domestic Violence Prevention, in Kampala, Uganda (Mar. 5, 2012) (on file with the Center for Reproductive Rights).

²⁰ These obligations are discussed in the introductory statements preceding the testimonials. *Also see*, CENTER FOR REPRODUCTIVE RIGHTS, INTERNATIONAL JURISPRUDENCE: DENYING ACCESS TO SAFE AND LEGAL ABORTION VIOLATES FUNDAMENTAL HUMAN RIGHTS (2012), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/crr_abortion_access_jurisprudence_v5.pdf [hereinafter INT’L JURISPRUDENCE].

²¹ TECHNICAL GUIDE (2012), *supra* note 8.

²² *See* Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, U.N.T.S. 13 (*entered into force* Sept. 3, 1981) (*ratified* Jul. 22, 1985) [hereinafter CEDAW]; International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976) (*accession on* Jun. 21, 1995); the International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No.16, U.N. Doc. A/6316 (1966)(*entered into force* Jan. 3, 1976) (*accession on* Jan. 21, 1987); the Convention on the Rights of the Child, *adopted* Nov. 20, 1989, G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49 (1989) (*entered into force* Sept. 2, 1990) (*ratified* Aug. 17, 1990) [hereinafter CRC]; Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2nd Ordinary Sess., Assembly of the Union, *adopted* July 11, 2003, CAB LEG/66.6 (*entered into force* Nov. 25, 2005) (*ratified* Jul. 22, 2010) [hereinafter Maputo Protocol].

²³ *See, e.g.*, Committee on the Elimination of Discrimination against Women (CEDAW Committee), *Concluding Observations: Burkina Faso*, para. 40, U.N. Doc. CEDAW/C/BFA/CO/6 (2010); *Cameroon*, para. 41, U.N. Doc. CEDAW/C/CMR/CO/3 (2009); *Kenya*, para. 38, U.N. Doc. CEDAW/C/KEN/CO/7 (2011); Committee on the Rights of the Child, *Concluding Observations: Burkina Faso*, para. 57, U.N. Doc. CRC/C/BFA/CO/3-4 (2010); *Nigeria*, para. 62, U.N. Doc. CRC/C/NGA/CO/3 4 (2010); Human Rights Committee, *Concluding Observations: Cameroon*, para. 13, U.N. Doc. CCPR/C/CMR/CO/4 (2010); Committee on Economic, Social and Cultural Rights (ESCR Committee), *Concluding Observations: Kenya*, para. 33, U.N. Doc. E/C.12/KEN/CO/1 (2008).

²⁴ CEDAW Committee, *Concluding Observations: Uganda*, para. 35, U.N. Doc. CEDAW/C/UGA/CO/7 (2010).

²⁵ Maputo Protocol, *supra* note 22, art. 2(1).

²⁶ UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA, *supra* note 4, at 4-5.

²⁷ K.L. v. Peru, Human Rights Committee, Commc’n No. 1153/2003, para. 6.3, U.N. Doc. CCPR/C/85/D/1153/2003 (2005). For additional cases, *see* INT’L JURISPRUDENCE, *supra* note 20.

²⁸ L.C. v. Peru, CEDAW Committee, Commc’n No. 22/2009, U.N. Doc. CEDAW C/50/D/22/2009 (2011). *See* INT’L JURISPRUDENCE, *supra* note 20.

²⁹ Interview with Hajara, Muslim Center for Justice & Law, in Kampala, Uganda (Mar. 7, 2012) (on file with the Center for Reproductive Rights).

³⁰ Interview with Elizabeth (name has been changed), government official (Mar. 7, 2012) (on file with the Center for Reproductive Rights).

³¹ Name has been changed.

³² Interview with Maureen (name has been changed), maternal health advocate (Mar. 5, 2012) (on file with the Center for Reproductive Rights).

³³ Interview with Rachael Mwanga, peer educator, Moonlight Star Clinic, in Kampala, Uganda (Mar. 6, 2012) (on file with the Center for Reproductive Rights).

³⁴ Note that in Uganda, the average monthly household income is UGX 303,700—about USD 115. UGANDA BUREAU OF STATISTICS, UGANDA NATIONAL HOUSEHOLD SURVEY 2009/2010: ABRIDGED REPORT 93 (2010), *available at* <http://www.ubos.org/UNHS0910unhs200910.pdf>. Note also that the African Development Bank estimates that 51% of people in Uganda live on less than USD 1 per day. Jason Bremner & Eric Zuehlke, *Policy Brief: Integrating Population, Health, and Environment in Uganda*, POPULATION REFERENCE BUREAU 1 (2009), *available at* <http://www.prborg/pdf09/phe-uganda.pdf>.

³⁵ Interview with Tewi, at the National Community of Women Living with HIV/AIDS (NACWOLA), Kampala, Uganda (Mar. 9, 2012) (on file with the Center for Reproductive Rights).

³⁶ MOH, NAT’L POLICY GUIDELINES & SERVICE STANDARDS (2006), *supra* note 13, at 45; TECHNICAL GUIDE (2012), *supra* note 8, at 35–36.

³⁷ Interview with Nicki (name has been changed), high school student, in Kampala, Uganda (Mar. 9, 2012) (on file with the Center for Reproductive Rights).

³⁸ Interview with Husain (name has been changed), a male Ugandan secondary school student, in Kampala, Uganda (Mar. 9, 2012)



(on file with the Center for Reproductive Rights).

³⁹ Interview with Josephine (name has been changed), Ugandan women’s rights lawyer, in Kampala, Uganda (Mar. 4, 2012) (on file with the Center for Reproductive Rights).

⁴⁰ Interview with Ms. Peters (name has been changed), principal state attorney & head of the Gender and Sexual Offenses Division, in Kampala, Uganda (Mar. 6, 2012) (on file with the Center for Reproductive Rights).

⁴¹ Penal Code Act, Cap. 120, secs. 141-143 (Uganda).

⁴² Interview with Roselyn, Reproductive Health Services NGO worker, in Uganda (Mar. 5, 2012) (on file with the Center for Reproductive Rights).

⁴³ Interview with Dr. Collins Tusingwire, *supra* note 16.

⁴⁴ MOH, NAT’L POLICY GUIDELINES & SERVICE STANDARDS (2006), *supra* note 13, at 45; TECHNICAL GUIDE (2012), *supra* note 8, at 35-36.

⁴⁵ *10 Key Points - Uganda*, *supra* note 15; TECHNICAL GUIDE (2012), *supra* note 8, at 36.

⁴⁶ *See* TECHNICAL GUIDE (2012), *supra* note 8, at 33; MINISTRY OF HEALTH & MACRO INT’L INC., UGANDA SERVICE PROVISION ASSESSMENT SURVEY 2007, 99, 118 (2008), *available at* <http://pdfusaid.gov/pdfdocs/PNADM577.pdf> [hereinafter 2007 USPA]; GABRIEL JAGWE WADDA ET AL., ABORTION MORBIDITY IN UGANDA: EVIDENCE FROM TWO COMMUNITIES 41-42 (Guttmacher Institute, 2006) (noting that public facilities are supposed to provide free care); MINISTRY OF HEALTH, PATIENTS’ CHARTER, art. 1 (2009) (“In a medical emergency a person is entitled to receive emergency medical care unconditionally in any health facility without having to pay any deposits or fees prior to medical care.” This includes post-abortion care.).

⁴⁷ Interview with Dr. Andrew, *supra* note 16.

⁴⁸ Interview with Sylvia Tamale, professor of law, in Kampala, Uganda (Mar. 5, 2012) (on file with the Center for Reproductive Rights).

⁴⁹ Interview with Sarah Kaddu, community activist at Centre for Domestic Violence

Prevention, in Kampala, Uganda (Mar. 9, 2012) (on file with the Center for Reproductive Rights).

⁵⁰ Interview with Peter Masinde, police nurse, in Mubende, Uganda (Mar. 8, 2012) (on file with the Center for Reproductive Rights).

⁵¹ CEDAW, *supra* note 22, arts. 10(h), 12, 14(2 (b)); ESCR Committee, *General Comment No. 14: The right to the highest attainable standard of health (Art. 12)*, (22nd Sess., 2000), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 78, paras. 14, 35, n. 12, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008); CRC, *supra* note 22, art. 24; Maputo Protocol, *supra* note 22, art. 14; CENTER FOR REPRODUCTIVE RIGHTS & UNITED NATIONS POPULATION FUND (UNFPA), BRIEFING PAPER: THE RIGHT TO CONTRACEPTIVE INFORMATION AND SERVICES FOR WOMEN AND ADOLESCENTS (2010), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/BP_unfpa_12.10.pdf [hereinafter THE RIGHT TO CONTRACEPTIVE INFO. & SERVICES].

⁵² CEDAW Committee, *Concluding Observations: Uganda*, para. 35, U.N. Doc CEDAW/C/UGA CO/7 (2010).

⁵³ *Id.* para. 36.

⁵⁴ THE RIGHT TO CONTRACEPTIVE INFO. & SERVICES, *supra* note 51, at 9.

⁵⁵ UGANDA BUREAU OF STATISTICS, UGANDA DEMOGRAPHIC AND HEALTH SURVEY 2006, 104 (2007), *available at* <http://www.measuredhs.com/pubs/pdf/FR194/FR194.pdf> [hereinafter 2006 UDHS]; WORLD BANK, REPRODUCTIVE HEALTH AT A GLANCE: UGANDA 1 (2011), *available at* <http://siteresources.worldbank.org/INTPRH/Resources/376374-1303736328719/Uganda42111WEB.pdf>. Uganda’s unmet need for family planning was second only to Samoa, where the unmet need was recorded at 45.6% in 2009. UN DEP’T OF SOC. & ECON. AFFAIRS, POPULATION DIV., WORLD ABORTION POLICIES 2011, 1 (2011), *available at* <http://www.un.org/esa/population/publications/2011-abortion/2011walchart.pdf>.

⁵⁶ 2006 UDHS, *supra* note 55, at 104.

⁵⁷ UGANDA BUREAU OF STATISTICS, UGANDA DEMOGRAPHIC AND HEALTH SURVEY 2011, 79 (2011), *available at* <http://www.measuredhs.com/pubs/pdf/FR264FR264.pdf>.

⁵⁸ GUTTMACHER INSTITUTE, *Benefits of Meeting the Contraceptive Needs of Ugandan Women*, IN BRIEF No. 4, 1 (2009), *available at* http://www.guttmacher.org/pubs/IB_Contraceptive-Needs_Uganda.pdf [hereinafter BENEFITS OF MEETING CONTRACEPTIVE NEEDS].

⁵⁹ 2007 USPA, *supra* note 46, at 88.

⁶⁰ 2006 UDHS, *supra* note 55, at 107; ABORTION & POSTABORTION CARE IN UGANDA, *supra* note 18, at 9.

⁶¹ Anthony K. Mbonye, *Risk Factors Associated with Maternal Deaths in Health Units in Uganda*, 5 AFR. J. OF REPRO. HLTH. 47, 52 (2001).

⁶² BENEFITS OF MEETING CONTRACEPTIVE NEEDS, *supra* note 58, at 1.

⁶³ Interview with Edith, commercial sex worker, Kampala, Uganda (Mar. 6, 2012) (on file with the Center for Reproductive Rights).

⁶⁴ *See supra* note 34.

⁶⁵ Interview with Nansubuga, Muslim Center for Justice & Law, in Kampala, Uganda (Mar. 7, 2012) (on file with the Center for Reproductive Rights).

⁶⁶ This is approximately USD 37. Conversion into USD found at: OANDA, Currency Converter, <http://www.oanda.com/currency/converter/> (last visited May 1, 2013). *See also supra* note 34.

⁶⁷ Interview with Joyce (name has been changed), a Ugandan woman (Mar. 2012) (on file with the Center for Reproductive Rights).

⁶⁸ Interview with Diana, woman living with HIV, in Kampala, Uganda (Mar. 9, 2012) (on file with the Center for Reproductive Rights).

⁶⁹ Interview with Annet, peer educator, in Kampala, Uganda (Mar. 6, 2012) (on file with the Center for Reproductive Rights).

⁷⁰ CEDAW, *supra* note 22. Uganda ratified CEDAW on July 22, 1985. United Nations Treaty Collection, http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV8&chapter=4&lang=en (last visited May 1, 2013).

⁷¹ Interview with Deus Kiwanyka, *supra* note 19.

⁷² MOH, NAT’L POLICY GUIDELINES & SERVICE STANDARDS (2006), *supra* note 13, at 20.

⁷³ Interview with Dora Musinguzi, executive director of Uganda Network on Law, Ethics & HIV/AIDS (UGANET) (Mar. 5, 2012) (on file with the Center for Reproductive Rights).

⁷⁴ MOH, NAT’L POLICY GUIDELINES & SERVICE STANDARDS (2006), *supra* note 13, at 20.

⁷⁵ Interview with Agnes (name has been changed), women’s rights NGO worker, in Kampala, Uganda (Mar. 6, 2012) (on file with the Center for Reproductive Rights).

⁷⁶ Interview with Dr. Milton Awudo, head of clinical services, Marie Stopes (Mar. 5, 2012) (on file with the Center for Reproductive Rights).

⁷⁷ TECHNICAL GUIDE (2012), *supra* note 8.

⁷⁸ Interview with Solomy (name has been changed), a Ugandan woman, in Kampala, Uganda (Mar. 9, 2012) (on file with the Center for Reproductive Rights).

⁷⁹ Interview with the Hon. Monicah Amoding, Member of Parliament, in Uganda (Mar. 5, 2012) (on file with the Center for Reproductive Rights).

⁸⁰ Interview with the Hon. Sylvia Ssenabulya, Member of Parliament, Committee of Social Services, chairperson of Network on Maternal and Reproductive Health, in Uganda (Mar. 7, 2012) (on file with the Center for Reproductive Rights).

⁸¹ Interview with Irene B. Ddamulira, a domiciliary midwife, in Mubende, Uganda (Mar. 8, 2012) (on file with the Center for Reproductive Rights).

⁸² Interview with Anna (name has been changed), member of Uganda Private Midwives Association (Mar. 5, 2012) (on file with the Center for Reproductive Rights).

⁸³ Cephalopelvic disproportion occurs when the head of the baby being born is too large to pass through the mother’s pelvis and thus causes prolonged and obstructed labor. It is a major factor in the development of fistulas – that is, holes – between the vagina and rectum or bladder, which cause constant leakage of wastes through the vagina and social ostracism of the mother. *See* OperationOF, *Cephalopelvic Disproportion* (CPD), <http://www.operationof.org/fistula/causes/obstructed-labor/cpd/> (last visited Jun. 17, 2013).

⁸⁴ Interview with Zamu Kaboneke, Leadership and Advocacy for Women in Africa (LAWA) alumna, in Uganda (Mar. 4, 2012) (on file with the Center for Reproductive Rights).

⁸⁵ Interview with Emma (name has been changed), United Nations Population Fund (UNFPA) official, in Kampala, Uganda (Mar. 7, 2012) (on file with the Center for Reproductive Rights).

⁸⁶ See introductory statements at the beginning of both sets of testimonials.