



## BRIEFING PAPER

# A TECHNICAL GUIDE TO UNDERSTANDING THE LEGAL AND POLICY FRAMEWORK ON TERMINATION OF PREGNANCY IN UGANDA

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A TECHNICAL GUIDE TO  
UNDERSTANDING THE LEGAL  
AND POLICY FRAMEWORK  
ON TERMINATION OF  
PREGNANCY IN UGANDA



Sudan

Torit

Lokichokio

Yei

Aba

Faradje

Moyo

Kaabong

Kenya

# Uganda

Atiak

Kitgum

Arua

Moroto

Ora

Northam

Pakwach

Lira

Okok  
Okere

Zaire

Lake Kwanaia

Lake Albert

Butiaba

Masindi

Lake Bisina

Bunia

Lake Kyoga

Soroti

Kapchorwa

Hoima

Kafu

Mbale

Nkusi

Namasagali

Kitale

Fort Portal

Kyenjojo

Mubende

Bombo

Mbulamuti

Busembatia

Tororo

Iganga

Mityana

Kampala

Jinja

Butere

Kasege

Lake George

Ntusi

Masaka

Lyantonde

Sese Islands

Entebbe

Kisumu

Mbarara

Kisii

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Lake Victoria

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# INTRODUCTION

This technical guide seeks 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.

The laws and policies governing termination of pregnancy in Uganda are inconsistent, unclear, and often contradictory. The confusing content of these laws and policies is compounded by their limited interpretations by Ugandan courts and other government authorities, such as the statutory councils established to regulate the health care professions. As a result, women, health care providers, and regulators often lack comprehensive information about the content of the law and what it permits.

Further, access to information that may help shed light on this legal and policy environment is extremely restricted. For example, it is difficult and time-consuming to obtain a copy of the Ministry of Health's 2006 *National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights*—the only government-issued document that clearly outlines the circumstances under which abortion may be provided in Uganda. Very few copies appear to be in circulation, and the Ministry of Health itself no longer has copies for distribution. As a result, few health care providers seem to know about or possess a copy of these guidelines, leaving them unfamiliar with the permitted grounds for providing safe and legal abortions listed in this government-issued policy document.

The following key findings are based on an extensive review of relevant policies, guidelines, training manuals, curricula, and professional codes of conduct and ethics; an analysis of key laws, court cases, and legal texts; and interviews with lawyers, health care providers and administrators, advocates, and academics in Uganda.

The single most critical finding of our research is that **Uganda's laws and policies are more expansive than most believe, and the current legal and policy framework offers ample opportunities for increasing access to safe abortion services.**

# RECOMMENDATIONS

To ensure Uganda's compliance with its international and regional human rights obligations and to reduce maternal death and disability from unsafe abortion in Uganda, we make the following recommendations to the Ugandan Government:

- **Raise awareness among health care providers, women, and communities about the true content and scope of the law on termination of pregnancy in Uganda and ensure that existing exceptions are available in practice.**
- **Ensure wide dissemination of, and training on, the 2006 *National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights (National SRH Guidelines)*, particularly the section on termination of pregnancy.**
- **Ensure that the relevant health care providers—including mid-level providers, as set forth in the 2006 *National SRH Guidelines*—are trained to provide safe abortion and post-abortion care services and that health care facilities are appropriately equipped to provide these services.**
- **Remove its reservations to article 14 of the Protocol on the Rights of Women in Africa (Maputo Protocol) to the African Charter on Human and Peoples' Rights and domesticate the Protocol.**





# WHAT ARE UGANDA'S OBLIGATIONS UNDER INTERNATIONAL AND REGIONAL HUMAN RIGHTS LAWS AND STANDARDS?

## IN SUMMARY:

- **Uganda has ratified international and regional treaties that affirm women's human rights.**
- **International and regional human rights standards have established that access to safe and legal abortion and post-abortion care is essential to protecting women's most fundamental human rights.**
- **Although Uganda has made reservations to article 14(2)(c) of the Maputo Protocol, which concerns access to abortion, this has *no* effect on Uganda's existing abortion law—nor does it prevent future changes to that law.**

Several regional treaties ratified by Uganda—the African Charter on Human and Peoples' Rights (African Charter),<sup>1</sup> the African Charter on the Rights and Welfare of the Child (African Charter on Children),<sup>2</sup> and the African Charter's Protocol on the Rights of Women in Africa (Maputo Protocol)<sup>3</sup>—provide important protections for the rights of women and girls in Uganda.

Uganda has also confirmed its commitment to upholding international human rights standards by ratifying several major global treaties, including the International Covenant on Civil and Political Rights (ICCPR),<sup>4</sup> the International Covenant on Economic, Social and Cultural Rights (ICESCR),<sup>5</sup> the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW),<sup>6</sup> the Convention on the Rights of the Child (Children's Rights Convention),<sup>7</sup> and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention against Torture).<sup>8</sup>

The Government of Uganda is legally bound to respect, protect, and fulfil the rights contained in the international and regional conventions that it has signed or ratified. The Ugandan Government's failure to ensure access to safe termination of pregnancy and post-abortion care, and the criminalization of abortion, are direct evidence of a failure to safeguard women's rights to

- life;
- health;
- liberty and security of person;
- freedom from torture and cruel, inhuman, and degrading treatment;
- equality and non-discrimination;
- dignity;
- information;
- privacy and family; and
- redress and legal assistance.

A state that ratifies or accedes to an international convention “establishes on the international plane its consent to be bound by a treaty.”<sup>9</sup> The Government of Uganda is therefore obligated under international law to protect the rights guaranteed by these instruments. While Uganda has not incorporated the vast majority of these treaties’ provisions into its national-level laws,<sup>10</sup> under the Vienna Convention on the Law of Treaties, “[a] party may not invoke the provisions of its internal law as justification for its failure to perform a treaty.”<sup>11</sup>

The Ugandan Constitution also makes clear the importance of “respect for international law and treaty obligations,”<sup>12</sup> and treaties that have been ratified but not yet domesticated are still considered persuasive authorities by Ugandan courts. Decisions by the Ugandan Constitutional Court repeatedly refer to international human rights treaties to which Uganda is a party, stating that decisions of treaty-monitoring bodies are “very persuasive in our jurisdiction”;<sup>13</sup> that the Court “ought to interpret our law so as not to be in conflict with the international obligations that Uganda assumed when it acceded to [a human rights treaty]”;<sup>14</sup> and that “where the words of the Constitution or other law are ambiguous or unclear or are capable of several meanings,” the Court may look to “international instruments to which this court has acceded and thus elected to be judged in the community of nations.”<sup>15</sup> In so doing, the Court has found at least one traditional practice in violation of such treaties.<sup>16</sup>

The legally binding provisions of the major human rights conventions are complemented by politically binding international consensus documents that support a globally recognized reproductive rights framework. These include the outcome documents of international conferences such as the United Nations International Conference on Population and Development, the Fifth African Regional Conference on Women, and the United Nations Fourth World Conference on Women—all of which Uganda participated in.<sup>17</sup> Moreover, Uganda has committed itself to attaining the United Nations Millennium Development Goals, which seek, among other things, to promote gender equality, reduce maternal mortality, and ensure universal access to education.<sup>18</sup>

## UGANDA AND THE MAPUTO PROTOCOL: RESERVATIONS TO ARTICLE 14

The Protocol on the Rights of Women in Africa (Maputo Protocol) to the African Charter on Human and Peoples’ Rights affirms reproductive choice and autonomy as a key human right. In addition, this groundbreaking Protocol represents the first time that an international human rights instrument has explicitly articulated a woman’s right to abortion in certain cases.

Uganda ratified the Maputo Protocol in July 2010, with two reservations, both relating to article 14 on health and reproductive rights. The first reservation pertains to the right to control one’s fertility. The second one, concerning access to abortion services, reads as follows:

*Article 14(2)(c) interpreted in a way conferring an*

*individual right to abortion or mandating State party to provide access thereto. The State is not bound by this clause unless permitted by domestic legislation expressly providing for abortion.*

*The Republic of Uganda makes this ratification on the understanding that the above clause [ ] of the present Protocol shall not apply to the Republic of Uganda.<sup>19</sup>*

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

# WHAT DOES THE UGANDAN CONSTITUTION SAY ABOUT TERMINATION OF PREGNANCY?

## IN SUMMARY:

- **Contrary to popular belief, article 22(2) of the Constitution does *not* prohibit abortion.**
- **The Constitution contains key provisions that support access to safe and legal abortion services and post-abortion care. It affirms the importance of respecting human dignity, protecting people from inhuman treatment, and according women full and equal dignity.**

## Article 22(2)

Uganda is one of only four African countries that directly address termination of pregnancy in their constitutions.<sup>20</sup> Article 22(2) of the Ugandan Constitution, concerning “protection of right to life,” states, **“No person has the right to terminate the life of an unborn child except as may be authorised by law.”**<sup>21</sup> This provision does not preclude access to abortion. Instead, it merely stipulates that there is no right on the part of any person—whether the provider or the pregnant woman—to terminate “the life of an unborn child” in the absence of a law permitting them to do so. As discussed below, Uganda does in fact have such a law: section 224 of the Penal Code.

### ***“unborn child”***

Significantly, article 22(2) of the Constitution refers not to termination generally but to the termination of the life of an “unborn child.” Neither the Constitution nor the Penal Code provides an explicit legal definition of this term, which is also used in two relevant provisions in the Penal Code: sections 212 and 224.

However, looking to the overarching framework of the Penal Code, and considering the text of section 212, the meaning of article 22(2) becomes clearer. Criminal law in Uganda deliberately treats as separate and distinct the crimes against a foetus,<sup>22</sup> a foetus about to be born,<sup>23</sup> and a born child,<sup>24</sup> and takes great care to define the precise moments at which a child is no longer considered a foetus and is instead considered either an “unborn child” or a born child and thus “a person capable of being killed.”<sup>25</sup>

Section 212 of the Penal Code concerns the crime of “killing an unborn child”—an act defined as occurring at the moment “when a woman is about to be delivered of a child.”<sup>26</sup> The term “unborn child” could therefore be interpreted as referring solely to a foetus that is “about to be delivered.” As such, this constitutional provision arguably refers *exclusively* to a foetus that is about to be born. [See Penal Code Section.]

In sum, the fact that the law so clearly distinguishes between the crime of killing an “unborn child” and an offence under section 141 or 142 of the Penal Code, relating to procuring an abortion or miscarriage,<sup>27</sup> limits the scope of this constitutional provision to circumstances pertaining to the intentional death of an “unborn child.”

### ***“except as may be authorised by law”***

With this phrase, article 22(2) of the Constitution provides for an express limitation on the prohibition on the termination of an “unborn child’s” life, leaving room for both statutory and common-law exceptions.<sup>28</sup> Regarding the former, Uganda’s Interpretation Act of 1976 defines “written law” as “constitutional instruments, Acts, statutory instruments and any other legislative instruments having effect in Uganda.”<sup>29</sup> An analysis of Uganda’s legislation reveals that one such authorizing law under article 22(2) of the Constitution is section 224 of the Penal Code, which absolves persons of criminal liability if they perform, in good faith, a surgical operation on an “unborn child” in order to preserve the pregnant woman’s life.<sup>30</sup> [See Penal Code Section for additional analysis of this and other provisions.]

### **Other Key Constitutional Provisions**

A number of other provisions in the Ugandan Constitution support an expansive interpretation of legal access to abortion and post-abortion care. Although there is no explicit constitutional right to health, the state has an obligation to “ensure that . . . all Ugandans enjoy rights and opportunities and access to . . . health services.”<sup>31</sup> The Constitution also provides that “[t]he State shall take all practical measures to ensure the provision of basic medical services to the population.”<sup>32</sup> These provisions make clear that the government has an obligation to train enough health care providers and provide the necessary equipment to offer abortion-related services. Restrictive abortion laws and the failure to provide quality termination of pregnancy and post-abortion care services violate the right to health.

Although these obligations are found in the “National Objectives and Directive Principles of State Policy” section of the Constitution, and as such are not generally considered justiciable or enforceable,<sup>33</sup> they still place meaningful obligations upon the government. The Constitution states clearly that the “objectives and principles shall guide all organs and agencies of the State, all citizens, organisations and other bodies and persons in applying or interpreting the Constitution or any other law and in taking and implementing any policy decisions for the establishment and promotion of a just, free and democratic society.”<sup>34</sup> In this spirit, the Patients’ Charter is explicitly derived from the

medical-services provision in the national objectives.<sup>35</sup> [See Regulating the Provision of Care Section.]

In addition, a 2005 constitutional amendment gives these objectives and directives the potential for greater legal authority. Article 8A on national interest, which is located in the justiciable section of the Constitution, provides that

- (1) *Uganda shall be governed based on principles of national interest and common good enshrined in the national objectives and directive principles of state policy.*
- (2) *Parliament shall make relevant laws for purposes of giving full effect to clause (1) of this article.*<sup>36</sup>

According to one Ugandan legal scholar, “article 8A’s location in the body of Constitution gives the imperative to give legal effect to the objectives.”<sup>37</sup> Further, “an integrated reading of the Constitution . . . reads the objectives together with the provisions in the bill of rights.”<sup>38</sup> According to this scholar, “Constitutional justification for this approach would be found in article 50 of the Constitution, which entitles any person who claims that a fundamental or other right or freedom guaranteed under this Constitution has been infringed or threatened to apply to a competent court for redress which may include compensation.”<sup>39</sup>

In other words, the Constitution requires that Parliament give effect to the national objectives through legislation, and then mandates that violations of such rights or freedoms receive redress. As the scholar further notes:

*Indeed, evidence from the courts shows a willingness of Ugandan judges to use article 50 to promote economic and social rights and to broaden the scope of application of the Directive Principles. . . . [This] is indicative of the high potential and possibility in Uganda to give economic and social rights judicial enforcement in spite of their incomprehensive domestication.*<sup>40</sup>

There are also a number of relevant and clearly justiciable rights contained in the Constitution. For example, children’s right to medical treatment is also affirmed in the Constitution, which states that “[n]o child shall be deprived by any person of medical treatment, education or any other social or economic benefit by reason of religious or other beliefs.”<sup>41</sup> This provision may be particularly important in the parental-consent context and could serve to support children’s right to access comprehensive abortion care, regardless of the parent’s personal religious beliefs concerning the procedure. Similarly, it may be useful in contexts where a child has been denied safe abortion services as a result of a provider’s personal objection to providing a service. All of these health-related provisions support increased access to safe abortion services in cases where the pregnancy poses a risk to the pregnant woman’s life or health, as well as increased access to post-abortion care.

Article 22 of the Constitution, discussed in part above, provides protection for the right to life. Forcing women to resort to life-threatening, unsafe abortions, due to restrictive abortion laws or a lack of access to safe abortion services, is a violation of their right to life. Similarly, a failure to ensure the availability and accessibility

of quality post-abortion care—an emergency, life-saving service—violates women’s right to life.

Article 24 of the Constitution concerns “[r]espect for human dignity and protection from inhuman treatment” and states that “[n]o person shall be subjected to any form of torture or cruel, inhuman or degrading treatment or punishment.”<sup>42</sup> This provision could be used to argue that denying post-abortion care or safe and legal abortion services in circumstances where the pregnancy may be a threat to a woman’s life, physical health, or mental health—particularly in cases of rape, incest, or severe foetal anomaly—violates her right to be free from torture and cruel, inhuman, and degrading treatment.<sup>43</sup>

Article 32(2) of Uganda’s amended Constitution explicitly prohibits “[l]aws, cultures, customs and traditions which are against the dignity, welfare or interest of women . . . or which undermine their status. . . .”<sup>44</sup> This article offers strong legal support for arguments in favour of decriminalizing abortion in Uganda. As highlighted in the International and Regional Human Rights Law Section, laws criminalizing abortion violate women’s right to dignity. In addition, by forcing women to resort to unsafe abortion, which often leads to disability or death, these laws are undeniably detrimental to women’s welfare and interest. As such, the Penal Code provisions criminalizing abortion could be understood as prohibited by the Constitution under article 32(2).

The Constitution also contains a provision exclusively on the rights of women, which reads:

*Article 33. Rights of women.*

- (1) *Women shall be accorded full and equal dignity of the person with men.*
- (2) *The State shall provide the facilities and opportunities necessary to enhance the welfare of women to enable them to realise their full potential and advancement.*
- (3) *The State shall protect women and their rights, taking into account their unique status and natural maternal functions in society.*
- (4) *Women shall have the right to equal treatment with men and that right shall include equal opportunities in political, economic and social activities.*
- (5) *Without prejudice to article 32 of this Constitution, women shall have the right to affirmative action for the purpose of redressing the imbalances created by history, tradition or custom.*<sup>45</sup>

Article 33(2) requires the Ugandan Government to increase access to and the availability of reproductive and maternal health care services and clinics for women, which would include family planning services and comprehensive abortion care, “to enable [women] to realise their full potential and advancement.” Article 33(3) requires the government to ensure women’s access to safe abortion services under the law, as it obligates the state to make certain that women’s “natural maternal functions” and “unique status”—only women

can get pregnant and may need access to safe and legal abortion—do not render them vulnerable to violations of their rights, including their rights to life and health.

The Constitution also protects the right to informational privacy. Article 27 provides that “[n]o person shall be subjected to interference with the privacy of that person’s home, correspondence, communication or other property.”<sup>46</sup> This provision constitutionally protects provider–patient confidentiality by prohibiting interference in the privacy of any communications between these parties, including those concerning abortion services. Such communications may pertain to the availability of services, where one may obtain the procedure, the types of abortion services available (surgical or medical), and instructions on how to safely procure a medication abortion.

Further, article 41 of the Constitution mandates that “[e]very citizen has a right of access to information in the possession of the State or any other organ or agency of the State except where the release of the information is likely to prejudice the security or sovereignty of the State or interfere with the right to the privacy of any other person.”<sup>47</sup> This provision prohibits public access to personal information or documents, such as medical records that may concern abortion-related care, on the basis of an individual’s constitutional right to privacy.<sup>48</sup>

Finally, the Constitution states that “[t]he rights, duties, declarations and guarantees relating to the fundamental and other human rights and freedoms specifically mentioned in this Chapter shall not be regarded as excluding others not specifically mentioned.”<sup>49</sup> This creates a space for the protection of additional human rights that are guaranteed in international and regional human rights treaties and which are not explicitly provided for in the Constitution of Uganda.

# THE UGANDAN PENAL CODE: WHEN IS TERMINATION OF PREGNANCY PERMITTED?

## IN SUMMARY:

- The Penal Code provisions on termination of pregnancy are frequently misunderstood as a total prohibition on abortion. This is not the case.
- Sections 141–143 of the Penal Code criminalize only “unlawful” acts related to termination of pregnancy, indicating that there are circumstances where pregnancies can be lawfully terminated.
- A lawful termination of pregnancy includes one performed to preserve the woman’s life or her mental or physical health.
  - Section 224 creates a clear exception to criminalization in cases where a termination is necessary to preserve the woman’s life. Case law has further clarified that this life exception encompasses mental and physical health as well. [See Case Law Section.]
- In addition, Uganda’s Penal Code provisions offer different protections for a foetus (sections 141–143), a foetus about to be born (section 212), and a born child (section 197). Only a “born child” can be the victim of murder or manslaughter under the Penal Code, as only a “born child” is a “person” within the meaning of the law.

## Sections 141–143

The only direct references to the substantive “crime” of abortion in Ugandan legislation can be found in the Penal Code.<sup>50</sup> Sections 141–143 criminalize attempting to procure, or knowingly supplying things to procure, an “unlawful” abortion or miscarriage. These sections refer to the criminal liability of the provider/procurer, the pregnant woman, and the supplier of drugs or equipment for abortion, respectively.

**141. Attempts to procure abortion.** *Any person who, with intent to procure the miscarriage of a woman whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means, commits a felony and is liable to imprisonment for fourteen years.*

**142. Procuring miscarriage.** *Any woman who, being with child, with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means, or permits any such things or means to be administered to or used on her, commits a felony and is liable to imprisonment for seven years.*



**143. Supplying drugs, etc. to procure abortion.** *Any person who unlawfully supplies to or procures for any person any thing, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman, whether she is or is not with child, commits a felony and is liable to imprisonment for three years.*<sup>51</sup>

There are several points worth noting about sections 141–143. First, all three provisions use the word “unlawfully” to describe the offence—i.e., “unlawfully administers” or “unlawfully supplies.” As discussed in the Case Law Section, courts have understood the use of the word “unlawfully” to be intentional and to suggest that there are circumstances under which these acts may be deemed lawful.<sup>52</sup>

Second, only section 142, which pertains to the pregnant woman, requires that the woman actually be pregnant in order to have committed an offence. Sections 141 and 143 apply whether or not the woman is, in fact, pregnant—instead, the intent of the person to procure the miscarriage triggers criminal liability. As such, there is an extra burden of proof for the prosecution to show beyond a reasonable doubt that the woman was pregnant in cases where the woman is the accused.

Finally, unlike article 22(2) of the Constitution and sections 212 and 224 of the Penal Code, sections 141–143 do not refer to the “unborn” but exclusively to unlawful “abortion” or “miscarriage.” The Penal Code does not define either “abortion” or “miscarriage,” and the terms do not appear to be defined in other Ugandan legislation.<sup>53</sup> Because there is no reference to gestational age in these provisions, they appear to apply to all stages of pregnancy.

## **Sections 197 and 212**

These sections of the Ugandan Penal Code seek to clarify the distinction between the offence of unlawfully procuring a miscarriage/abortion and that of murder or manslaughter. These sections define the moment in foetal development when a foetus becomes an “unborn child” and then a legal “person” whose destruction carries quite different, and harsher, penalties than those associated with abortion or termination of pregnancy.

**197. When child deemed a person.** *A child becomes a person capable of being killed when it has completely proceeded in a living state from the body of its mother, whether it has breathed or not, and whether it has an independent circulation or not, and whether the naval string is severed or not.*<sup>54</sup>

**212. Killing unborn child.** *Any person who, when a woman is about to be delivered of a child, prevents the child from being born alive by any act or omission of such a nature that if the child had been born alive and had then died, he or she would be deemed to have unlawfully killed the child, commits a felony and is liable to imprisonment for life.*<sup>55</sup>

Sections 197 and 212 reflect the state’s decision to offer differing protections for a foetus, a foetus that is about to be born, and a born child. Section 197 makes

clear that the offence of murder or manslaughter becomes applicable only when the foetus is born alive and physically exists outside the pregnant woman's body. In other words, the section distinguishes between a foetus in the womb and a newborn child, clarifying that a foetus yet to be born cannot be the victim of murder under the Penal Code.<sup>56</sup>

As one Ugandan legal scholar has explained, Section 212 “provides for the conviction of a person who destroys a child in the process of birth, in circumstances where it could not be proved that the child had completely proceeded in a living state from its mother's body, so as to be in law, capable of being killed.”<sup>57</sup> It is important to recognize that the provision's applicability is limited to a specific circumstance—i.e., “when a woman is about to be delivered of a child”<sup>58</sup> or, put another way, when she is “in the process of birth.”<sup>59</sup> The provision is meant to address the in-between stage where a child is “neither a fetus nor a born person.”<sup>60</sup> Under this provision, a person is criminally liable for destroying a foetus once a woman is in labour—subject, of course, to the “good faith” exception codified in section 224 (see below).

This understanding of the provision is consistent with dicta in a key English criminal case from 1938, *Rex v. Bourne*, discussed in further detail in the Case Law Section. The case may help explain the rationale behind including this provision in the Penal Code, as section 212 was likely modelled after an English law from 1929 that was referenced in *Bourne*.<sup>61</sup> The judge in *Bourne* explained that

*[t]here arose a case in which it was thought that provision had to be made: where an accoucheur, while a woman was being delivered of a full-term child—because the child was not wanted—killed it before it had an existence independent of its mother, and yet in circumstances that did not amount to the procurement of abortion, because the child was being delivered at full time in the ordinary course of nature.*<sup>62</sup>

The judge further explained that “Parliament thought right to provide for that case. Of course it is a case that would very rarely arise, and even much more rarely ever be known of.”<sup>63</sup>

Section 212 helps clarify the Ugandan Constitution's provision that “[n]o person has the right to terminate the life of an *unborn child* except as may be authorised by law.”<sup>64</sup> In light of the above analysis, the constitutional provision arguably refers only to the circumstances set out in section 212—namely, where a foetus is about to be born—as this is the only law in Uganda that suggests a possible legal definition of an “unborn child.” [See Constitution Section.]

## Section 224

**224. Surgical operation.** *A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his or her benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the*

*operation is reasonable, having regard to the patient's state at the time, and to all the circumstances of the case.*<sup>65</sup>

**This critical provision is widely understood to permit termination of pregnancy to safeguard the life and health of the pregnant woman. It creates a lawful exception to criminalization and provides a defence in circumstances where a person, in good faith and with reasonable care and skill, performs a surgical abortion to preserve the pregnant woman's life. In such circumstances, the person performing the procedure is not criminally liable.**

***“A person is not criminally responsible . . .”***

Section 224 stipulates that a “person” is not criminally responsible for performing a surgical operation where the operation is done “in good faith and with reasonable care and skill.” This echoes the “person” language in section 142 and provides a potential defence to anyone, subject to the good-faith qualification. This provision could therefore serve as a defence for any qualified health care provider, including nurses, allied health professionals, medical practitioners, and obstetrician/gynaecologists. This section does not, however, provide a defence for either the woman herself (section 142) or the person supplying the drugs or instruments used to procure the abortion (section 143).

***“for performing in good faith”***

The “good faith” requirement is critical to the determination of criminal guilt or innocence—to deny a person the defence under this section, the prosecution must prove beyond a reasonable doubt that the individual “had a criminal intention or did not act in good faith.”<sup>66</sup> This is a subjective determination, and, as legal scholar Rebecca Cook has explained, “the possibility that different assessments of the same situation may be made does not impair the conscientious and therefore lawful status of a liberal interpretation.”<sup>67</sup> In other words, there is no objective “right” answer; health care providers may reach different conclusions in the same case and still be acting in good faith.

Courts have determined that certain evidence may be particularly persuasive in determining a health care provider's good faith. Firstly, the decision to terminate the pregnancy must have been made on medical grounds. According to Professor Cook:

*[t]he requirement for a [health worker's] good faith in making a medical assessment of a woman's needs or qualification for abortion implies an obligation to apply proper professional criteria of health care and the absence of motivation based on ulterior or non-professional purposes. . . . [T]he decision must . . . be based on reasons of real danger to life or health, and not on financial and social factors as such. The underlying reasoning is that a physician's opinion not formed upon the basis of his special skill and trained insight is not a medical opinion.*<sup>68</sup>

Evidence of good faith may include “the absence of financial motivation”<sup>69</sup>—for example, “restraint in fee-setting” and refusing to accept a “sizeable fee”<sup>70</sup>; “the ability to use adequate skill”; or “making an adequate examination of the woman's medical history.”<sup>71</sup> Conversely, evidence that the person did not act in

good faith may lie in the “secrecy (as opposed to privacy) of the operation, failure to enquire into the woman’s circumstances to establish legal indications, and charging of high fees,”<sup>72</sup> as well as in “[p]ersonal involvement with the patient.”<sup>73</sup>

***“and with reasonable care and skill”***

This clause makes explicit that the surgical operation must be performed with reasonable care and skill.<sup>74</sup> Again, section 224 does not specify who might have such skills, instead referring to a “person” more generally. This leaves room for appropriately trained mid-level providers, such as nurses, midwives, and clinical officers, to provide the service, in addition to qualified medical practitioners.<sup>75</sup> Guidance as to who may have the requisite skills, and what constitutes the requisite “reasonable care,” may come in the form of policies or guidelines issued by the Ministry of Health. [See Government Policies Section for more information on where, how, and by whom abortions may be performed in Uganda.]

***“a surgical operation upon any person for his or her benefit, or upon an unborn child for the preservation of the mother’s life”***

Section 224 refers only to a “surgical operation,” which is not defined in the Penal Code. However, language in national health policies and interviews with Ugandan health care providers suggest that a surgical operation includes both dilation and curettage (D&C) and manual vacuum aspiration (MVA).

This provision refers to an “unborn child,” mirroring the language under article 22(2) of the Constitution. Section 224 of the Penal Code can thus be understood as an explicit “authorizing law” under article 22(2), which states, “[n]o person has the right to terminate the life of an unborn child except as may be authorised by law.”<sup>76</sup> As discussed above and in the Constitution Section, one could argue—in light of section 212—that this provision refers specifically to operating on a foetus that is about to be born (i.e., “an unborn child”) in order to preserve the woman’s life.

Defining “unborn child” in this way does not similarly limit the applicability of the life exception in section 224—this exception applies in any circumstance where a woman may need a termination of pregnancy. This was the judge’s holding in *Rex v. Bourne*, discussed in the Case Law Section. In essence, the judge read this broader exception “always to have been implicit in [the abortion provisions of the Penal Code], *on the reasoning that if preservation of the mother’s life justifies sacrificing the child’s life at the moment of birth, it also justifies such sacrifice at any earlier stage in pregnancy.*”<sup>77</sup>

Section 224 does not describe what circumstances may constitute operating “for the preservation of the [woman’s] life.” In addition, our research has revealed no post-independence Ugandan Supreme Court, Court of Appeal/Constitutional Court, or High Court case law that authoritatively interprets this provision and clarifies the content of this exception. However, two pre-independence cases—one from England and the other from the East African Court of Appeal—make clear that the life exception should be understood to encompass mental and

physical health grounds and pregnancies resulting from sexual violence. This understanding of the life exception also concurs with human rights standards on abortion. [See Case Law Section and International and Regional Human Rights Law Section.]

***“if the performance of the operation is reasonable, having regard to the patient’s state at the time, and to all the circumstances of the case”***

Finally, the provision also makes clear that in determining whether a surgically induced termination of pregnancy performed to preserve the woman’s life is reasonable under the law, the provider (and the magistrate or judge, in the event of a criminal case) should look to a range of factors and contextual information. First, the performance of the operation must be “reasonable,” indicating that it should be done under circumstances consistent with accepted contemporary medical practice and standards—or the “general opinion of competent practitioners.”<sup>78</sup> Further, the “patient’s state at the time, and . . . all the circumstances of the case” must be evaluated, creating space for a more expansive (or “reasonable”) judicial interpretation of “preserving the pregnant woman’s life” than simply the prevention of imminent death.



# WHAT ABORTION CASE LAW IS RELEVANT TO UGANDA?

## IN SUMMARY:

- There is no post-independence Ugandan case law interpreting the Ugandan Penal Code provisions on abortion. However, pre-independence case law, which continues to have legal authority in Uganda, can be used to interpret Uganda's abortion law.
- In Uganda, termination of pregnancy is permitted to preserve the life and health of the pregnant woman. Health is defined to include both physical and mental health. This understanding was elucidated in the widely recognized English case *Rex v. Bourne* (1938), a case that has been repeatedly affirmed throughout the Commonwealth, including by the East African Court of Appeal in *Mehar Singh Bansel v. R* (1959).
- The Ugandan Government has repeatedly acknowledged that the law on termination of pregnancy contains a life and mental and physical health exception. This was the position of the permanent secretary at the Ministry of Health in response to a survey distributed by the Commonwealth Secretariat in 1976;<sup>79</sup> the solicitor general in a 2002 legal memo to the director general of health services at the Ministry of Health;<sup>80</sup> and the Ministry of Health in at least three policy guidelines and training curricula that it issued between 2001 and 2007, permitting abortion in cases of sexual violence on mental health grounds.<sup>81</sup>

There is little applicable Ugandan case law to provide clear, interpretative guidance concerning the circumstances in which abortion may be legally provided and procured. No Constitutional Court case interprets Uganda's constitutional provision on termination or elucidates how this provision interacts with pre-existing provisions in Uganda's Penal Code; similarly, there are no Ugandan court cases interpreting the Penal Code's abortion provisions.

An interview with the Chief Magistrate in Kampala revealed that the magistrate's courts have ruled on very few cases relating to abortion.<sup>82</sup> The few cases that have been tried do not appear to elaborate on the meaning or content of the law. For example, the judgment in the sole abortion case tried by the current Chief Magistrate in Kampala, *Uganda v. Dr. S. Nawabul Hassan and Sebakaki Kenneth* (2008), did not analyse or interpret the Penal Code's abortion provisions. Instead, it was a straightforward application of section 141 to the actions of the accused in that case.<sup>83</sup>

However, pre-independence jurisprudence, which continues to have legal authority in contemporary Uganda,<sup>84</sup> can be used to interpret Uganda's abortion law.

## ***Rex v. Bourne***<sup>85</sup>

*Rex v. Bourne* was the first case to address the grounds upon which an abortion could be legally provided in England.<sup>86</sup> This case, decided in 1938, has had a profound and lasting impact on the legal regimes of former British colonies and Commonwealth countries. Most colonies, Uganda included, had—and continue to have—an abortion provision nearly identical to the one at issue in *Rex v. Bourne* in their penal codes and, under common-law principles, can look to British case law as an authoritative interpretation of that law.<sup>87</sup>

*Rex v. Bourne*, heard in the Central Criminal Court, was brought against a doctor who had performed an abortion on a young girl who had been raped.<sup>88</sup> The question at hand was whether the doctor had “unlawfully” procured the girl’s abortion. In his summing-up to the jury, the judge reasoned that the use of the word “unlawfully” in the provisions criminalizing abortion in the English Offences against the Person Act was intentional and suggested that there were circumstances under which abortion could be “lawfully” procured. For guidance, he then looked to the United Kingdom’s 1929 Infant Life (Preservation) Act, which provides an exception to the crime of child destruction for acts “done in good faith for the purpose only of preserving the life of the mother.”<sup>89</sup> He concluded that this life exception had “always . . . been implicit in [the procuring abortion provision] of the 1861 Act.”<sup>90</sup> In essence, the judge understood the abortion law to permit a person to “lawfully” procure a miscarriage if done “in good faith for the purpose only of preserving the life of the mother.”<sup>91</sup> Significantly, sections 141 and 142 of the Ugandan Penal Code, which criminalize “unlawful” abortion and miscarriage, are based on these provisions in the 1861 Act,<sup>92</sup> while section 224 (Uganda’s “good faith” exception) of the Penal Code is likely modelled after the United Kingdom’s 1929 legislation.<sup>93</sup> As such, by analogy, sections 141 and 142 can also be understood to import a lawful life exception to criminalization in Uganda.

The judge further asserted that the jury “should take a reasonable view of” the phrase “preserving the life of the mother.”<sup>94</sup> A reasonable view, according to the judge, does not mean “for the purpose of saving the mother from instant death”<sup>95</sup>—in such a case, the doctor is “not only entitled, but it is his *duty* to perform the operation with a view to saving her life.”<sup>96</sup> Rather, “if the doctor is of opinion, on reasonable grounds and with adequate knowledge, that the probable consequence of the continuance of the pregnancy will be to make the woman a physical or mental wreck,” then this constitutes acting in preservation of the life of the woman and is lawful.<sup>97</sup>

**The ruling in *Bourne* effectively created a mental and physical health exception to the criminalization of abortion—and clearly provided for access to legal abortion in cases of rape.** Unlike the surgical operation provision under section 224 of the Ugandan Penal Code, the *Bourne* decision does not refer to the termination method—it simply sets forth a general legal framework, permitting termination of pregnancy to preserve the pregnant woman’s life or health. Critically, the ruling therefore widens the defence beyond surgical abortion to include medication abortion. Finally, although *Bourne* concerns a doctor—the only type of provider



considered capable of safely offering these services when the case was decided in the 1930s—modern technology and professional competencies permit mid-level providers to offer certain abortion services as well.<sup>98</sup> This decision is broadly applicable to all health care providers who are appropriately trained and capable of offering termination-of-pregnancy services.

The judge's reasoning in *Bourne* emphasized the girl's age and the "fact that she had been raped with great violence."<sup>99</sup> At the time of the rape and subsequent abortion, the girl was under the age of fifteen. The judge noted that "[i]t is no doubt very undesirable that a young girl should be delivered of a child."<sup>100</sup> As support for this proposition, the judge relied on Parliament's legislative intent and medical testimony given at trial. He pointed to legislation prohibiting girls under sixteen from marrying as evidence of Parliament's "view that a girl under the age of sixteen ought not to marry and have a child," and pointed to medical evidence concerning girls' physical immaturity prior to the age of eighteen as confirmation that "it must be injurious to a girl that she should go through the state of pregnancy and finally of labour when she is of tender years."<sup>101</sup>

Article 31(1) of the Ugandan Constitution states that only men and women eighteen years and above "have the right to marry and to found a family."<sup>102</sup> Given this provision and the constitutional drafters' presumed legislative intent, combined with the continuing fact of girls' physical immaturity prior to the age of eighteen, it may be possible to argue for an exception to the criminalization of abortion for minors who become pregnant.

The judge also gave much weight to the fact that the girl was raped, stating that "a girl who for nine months has to carry in her body the reminder of the dreadful scene and then go through the pangs of childbirth must suffer great mental anguish."<sup>103</sup> This language offers clear legal support for a rape exception, stemming from health grounds, in Uganda.

Although *Bourne* was decided only by a court of first instance, not considered on appeal, and ultimately decided by a jury, there are compelling arguments for its significance for all common-law countries. Professor Cook has written persuasively on this issue:

*The strength of a case authority depends not simply upon its origin in the hierarchy of the courts . . . but upon the respect subsequent courts and legal literature accord to it. A case not binding as precedent, for instance because of its origin in another individual jurisdiction, may guide and persuade by accumulated authority.*

*The language used by Macnaghten, J. in directing the Bourne jury has received the highest approval. It occupies a distinguished place in legal literature not simply on abortion, but on the general legal concept and defence of necessity. To cast doubt on the authority of the Bourne decision is not just to favour a different opinion on the legal propriety of abortion, but to question the foundations of modern common law thought on recognition of the necessity concept. . . . Apart from the high status of the decision in British law, it has received wide citation and approval in courts of other Commonwealth countries.<sup>104</sup>*

## **Expanding upon and Affirming *Bourne*: Additional Jurisprudence**

In the two decades following *Rex v. Bourne*, two cases heard at the Central Criminal Court in England further affirmed, and arguably expanded upon, the judge's summing-up in that case. The first case was *Rex v. Bergman and Ferguson* (1948), which concerned two doctors indicted for "conspiring together unlawfully to procure miscarriage."<sup>105</sup> In his summing-up of this case, Justice Morris read directly from *Bourne*:

*If the doctor is of opinion, on reasonable grounds, and with adequate knowledge, that the probable consequence of the continuance of pregnancy would indeed make the woman a physical or mental wreck, juries are quite entitled to take the view that the doctor who in those circumstances and in that honest belief operates is operating for the purpose of preserving the life of the mother.*<sup>106</sup>

Justice Morris then stated, "I fully adopt those words and invite you to bear them very much in mind."<sup>107</sup>

The second case, *Reg. v. Newton and Stungo* (1958), concerned the specific issue of mental health grounds for abortion. In this case, in which a woman had died from an abortion performed by a doctor on mental health grounds, the doctor was charged with "unlawfully using an instrument with intent to procure [a] miscarriage," along with manslaughter and manslaughter on the grounds of negligence.<sup>108</sup> In his summing-up, Justice Ashworth stated, "The law on the use of an instrument for such a purpose was this—that it was unlawful unless the use was made in good faith for the purpose of preserving the life or health of the woman."<sup>109</sup> He then explained:

*Health meant not only physical but mental health as well. There might be cases of a woman going to a doctor in a state of great emotional upset, distraught, and verging on the fringe of insanity. If in such a case a doctor said, 'If I let this go on and I let her proceed to deliver she will be a mental wreck, if not dead,' and he then relieved the woman of her pregnancy, he committed no crime.*<sup>110</sup>

*Bourne* has also been affirmed in other jurisdictions.<sup>111</sup> In 1959, the East African Court of Appeal, which had jurisdiction over the territory of Uganda, affirmed the *Bourne* decision in *Mehar Singh Bansel v. R*, an abortion case on appeal from the Supreme Court of Kenya. In that case, the Supreme Court of Kenya defined an "illegal operation" as one "which is intended to terminate pregnancy for some reason other than what can, perhaps be best called a good medical reason," which the Court interpreted to be "the genuine belief that the operation is necessary for the purpose of saving the patient's life or preventing severe prejudice to her health."<sup>112</sup> The East African Court of Appeal affirmed the Kenyan

Supreme Court's conclusion.<sup>113</sup>

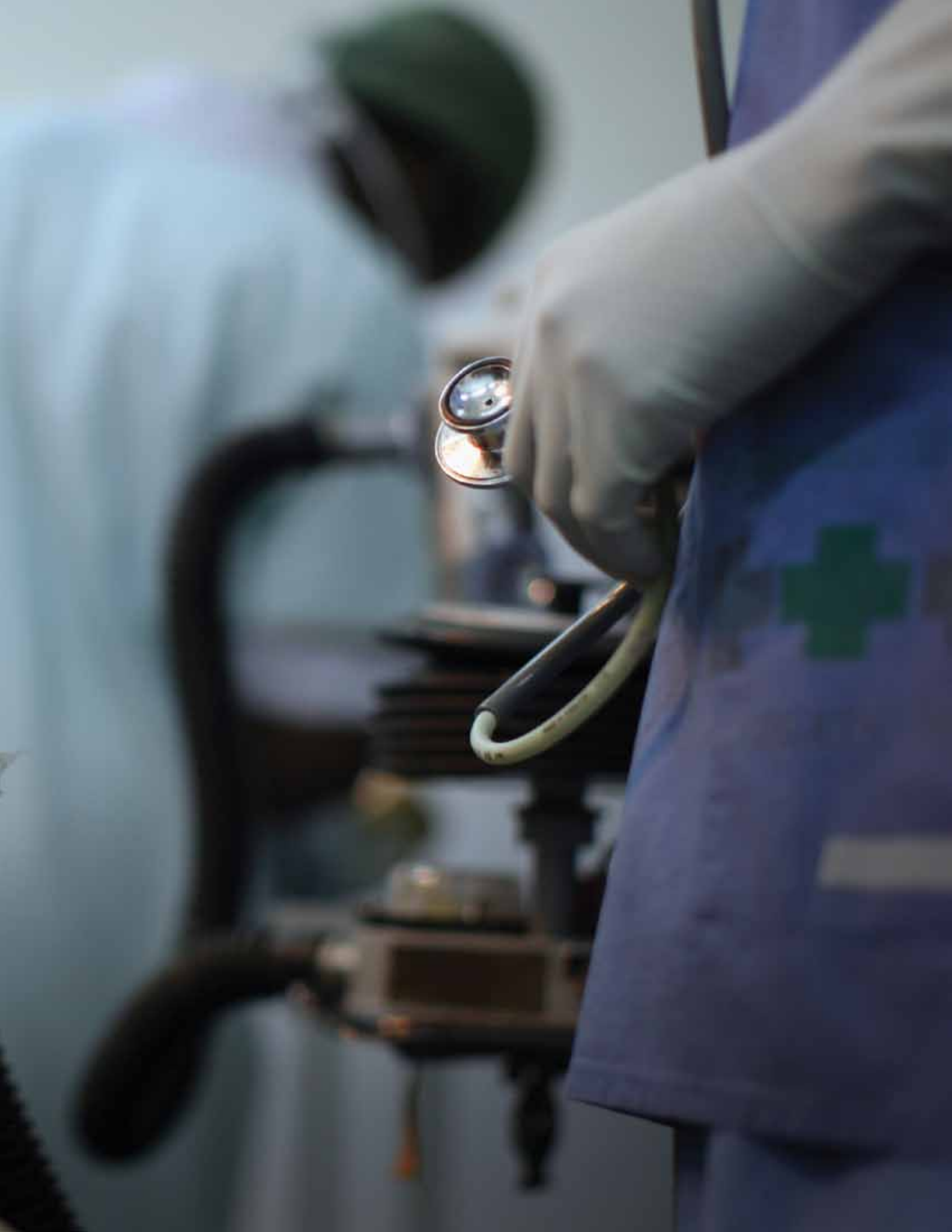
### **Post-Independence: Uganda Embraces the *Bourne* Decision**

In 1976, the Commonwealth Secretariat distributed a questionnaire to 36 member states and over 60 commonwealth jurisdictions to collect information about their abortion laws.<sup>114</sup> The Permanent Secretary in the Ugandan Ministry of Health responded to the survey on behalf of Uganda. His statement on the country's abortion law reflects the reasoning in *Bourne*: "I have to inform you that in this country abortion is acceptable for health and medical reasons and it is done only to save the life of the mother when it is threatened by the continuing pregnancy."<sup>115</sup> In addition, in the attached questionnaire, the Permanent Secretary clearly marked life, physical health, and mental health as distinct legal grounds for abortion in Uganda.<sup>116</sup>

The applicability of *Bourne* in Uganda was further affirmed by the Solicitor General in a 2002 memo written for the Director General of Health Services in the Ministry of Health. In the memo, the Solicitor General stated that *Rex v. Bourne* "introduced the common law health exception to the law against abortion" and explained that "[i]n Uganda abortions for health reasons are carried out on the basis of the English Common Law."<sup>117</sup> Our interviews with Ugandan lawyers confirmed the continuing applicability of and adherence to British case law in Uganda.<sup>118</sup> This deference applies to both new and old case law from the United Kingdom.<sup>119</sup>

### **HEALTH IS CONSISTENTLY UNDERSTOOD TO INCLUDE BOTH MENTAL AND PHYSICAL HEALTH**

The consistent understanding of health as encompassing both mental and physical health—as set forth in *Rex v. Bourne*, *Rex v. Bergman and Ferguson*, *Reg. v. Newton and Stungo*, and *Mehar Singh Bansel v. R*, as well as by the Ugandan Ministry of Health and the solicitor general—is significant and warrants emphasis. This understanding is in line with the World Health Organization's definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."<sup>120</sup>



# REGULATING THE PROVISION OF CARE IN UGANDA: WHAT DO PROFESSIONAL CODES OF CONDUCT AND THE PATIENTS' CHARTER SAY ABOUT TERMINATION OF PREGNANCY?

## IN SUMMARY:

- **No law, policy, regulation, or professional code of conduct in Uganda requires a health care provider to consult with one or more providers before performing a termination of pregnancy. Nor is this a legal requirement under common law.<sup>121</sup>**
- **There is no spousal consent requirement in any code of conduct for health professionals requiring that a woman obtain her husband's consent before receiving reproductive health services, including a termination of pregnancy.**
- **The various codes of conduct and the Ugandan Patients' Charter offer certain fundamental protections for all patients, including women requiring abortion and post-abortion care services.**

The Ugandan Government regulates the general provision of health care by health professionals in two primary ways. Each category of health care professional in Uganda is regulated by its own statutorily created body. At the same time, all health care workers can be held professionally accountable under the Ministry of Health's Patients' Charter, which outlines patients' rights and health workers' duties in the provision of quality health care. These regulatory frameworks are relevant in the context of abortion and post-abortion care service provision, as women seeking such services are often subject to serious abuses in health care facilities.

Termination of pregnancy, particularly in settings where it is criminalized, is often highly stigmatized, and women requiring termination of pregnancy or post-abortion care often face discrimination when attempting to access these services. These women may be subjected to physical and verbal abuse by health care providers, denied access to pain medications, or required to pay bribes to obtain care. Some providers may intentionally delay the provision of care to these women or refuse to provide referrals due to personal beliefs and biases concerning the procedure. Other providers, afraid of being seen as complicit in the procuring of an unlawful abortion, may deny women emergency post-abortion care and may even report them to the police, in violation of patient confidentiality.<sup>122</sup> As such, protections for patients' rights are critical to ensuring that women obtain quality abortion services, and that they receive such services free from discrimination.

## Professional Councils and Codes of Conduct for Health Care Professionals

Medical practitioners, allied health professionals, nurses and midwives, and pharmacists are each governed by their respective statutory scheme and code of conduct.<sup>123</sup> Each statutory scheme provides for a council that supervises, regulates, and disciplines the health care professionals within its jurisdiction. The councils are legally responsible for ethical oversight and for producing, disseminating, and enforcing a professional code of conduct. This code offers guidance to providers on their scope of practice, permitted behaviour, and expected professional conduct. Providers who violate this code of conduct are subject to professional sanction.

Despite popular belief that professional codes of conduct and ethics in Uganda proscribe or limit the provision of abortion services, our research revealed otherwise. **None of the official codes of conduct for specific cadres of health care professionals makes explicit reference to abortion or termination of pregnancy.**<sup>124</sup>

**Not one code mentions the general provision of abortion as constituting unlawful activity or professional misconduct, nor does any code discuss who can provide abortion services and under what circumstances.**

Finally, the codes of conduct do not require that providers consult with other health care professionals before performing a lawful termination of pregnancy.<sup>125</sup>

### THERE IS NO CONSULTATION REQUIREMENT UNDER UGANDAN LAW

Contrary to popular belief, none of Uganda's laws or policies requires that a provider consult with one or more providers before terminating a pregnancy. The origins of this misconception may be traced to English doctors' practice of consultation in cases of abortion in the early twentieth century. This practice was likely subsequently integrated into Ugandan medical practice and mistakenly understood as a requirement.

However, even in England, prior to the passage of the United Kingdom's 1967 Abortion Act, this was not a legal requirement but rather a practice recommended as prudent within the medical profession. According to a leading legal scholar, "there [wa]s nothing in English . . . law to require a second opinion"<sup>126</sup>; the "procedural restriction" of consultation simply "did not exist for the common law defence."<sup>127</sup> It was only in 1967 that the United Kingdom chose to codify this consultation requirement, at which time it became law in the United Kingdom.<sup>128</sup> There is no similar law in Uganda.

Nevertheless, our research indicated that there is a widespread belief among health care professionals—nurses, clinical officers, and obstetrician/gynaecologists alike—that there is a consultation or witness "requirement" for performing a legal abortion. Professionals differed in their opinions regarding the number of providers who need to be consulted and whether those consulted must be physicians, obstetrician/gynaecologists, or psychiatrists; however, the notion that such a legal consultation requirement existed was pervasive.

Sources of authority suggested for these requirements included the 1975 edition of the code of conduct for medical practitioners,<sup>129</sup> the Penal Code,<sup>130</sup> and even the original Ugandan Constitution.<sup>131</sup> However, as previously mentioned, **the requirement that a health care provider must consult with one or two other health care providers, physicians or specialists before providing an abortion cannot be found in the Constitution, any codes of conduct, or any laws or policies.**<sup>132</sup> **Given that this requirement is not codified in Uganda’s laws and policies, it cannot be understood as binding on health care professionals in the country.**<sup>133</sup>

Most contemporary legal and policy experts—including in the United Kingdom—agree that consultation requirements are inappropriate. For example, as stated by the United Kingdom’s House of Commons Science and Technology Committee in its 2007 report *Scientific Developments Relating to the Abortion Act 1967*:

**We were not presented with any good evidence that, at least in the first trimester, the requirement for two doctors’ signatures serves to safeguard women or doctors in any meaningful way, or serves any other useful purpose. We are concerned that the requirement for two signatures may be causing delays in access to abortion services. If a goal of public policy is to encourage early as opposed to later abortion, we believe there is a strong case for removing the requirement for two doctors’ signatures. We would like to see the requirement for two doctors’ signatures removed.**<sup>134</sup>

Delays in accessing abortion services due to consultation requirements are further compounded in resource-poor settings. Countries with limited resources often face serious shortages of physicians and other health care providers—obtaining the opinions of one or more additional health care providers before receiving an abortion may be impossible for many women, especially those living in rural areas with limited access to health care services and providers. Recognizing this reality, the Committee of Experts charged with drafting the 2010 Kenyan Constitution’s provision on termination of pregnancy declined both to include a consultation requirement and to limit service provision to physicians alone.<sup>135</sup>

In addition to delaying women’s access to safe abortion services, a consultation requirement also implies that abortion is a suspect procedure that demands extra scrutiny. Approval requirements run the risk of stigmatizing the practice and discouraging practitioners from providing abortions. This could result in a shortage of providers and a decline in the quality of services. As such, consultation requirements are understood as a procedural barrier and incompatible with governments’ duties to respect the human rights of women.<sup>136</sup>

### ***How Else Do the Codes of Conduct Protect Women Seeking Abortion-Related Services?***

Although the various health care professionals’ codes of conduct and ethics do not explicitly mention abortion, they do contain key provisions *relevant* to abortion and post-abortion services. For example, the codes for medical and dental practitioners, allied health professionals, and nurses and midwives all do the following:

- emphasize the importance of respect for patients' human rights;<sup>137</sup>
- prohibit discrimination in the management of patients;<sup>138</sup>
- mandate that the provider respect the patient's confidentiality and privacy;
- require that the provider obtain the patient's informed consent for treatment;<sup>139</sup> and
- obligate the provider to always provide emergency treatment to a patient.<sup>140</sup>

Similarly, pharmacists are required to ensure confidentiality and to place the welfare of their patient first, above all else.<sup>141</sup> These provisions demonstrate that health care professionals with the requisite skills are obligated, at a minimum, to offer quality termination of pregnancy services to safeguard a woman's life or health and to provide prompt and respectful post-abortion care services.

### **THE CODES FOR ALL FOUR CATEGORIES OF HEALTH PROFESSIONALS DISCUSSED ABOVE INCLUDE THE FOLLOWING EXAMPLES OF PROFESSIONAL MISCONDUCT:**

- behaving rudely or disrespectfully towards patients;
- disclosing patient information without the patient's permission;
- failing to refer a patient where indicated; and
- acting negligently towards the patient.<sup>142</sup>

These provisions may be useful for women seeking redress for abuses experienced in the health care setting in the context of abortion-related services.

### **The Patients' Charter**

In December 2009, the Ministry of Health published the Patients' Charter. The Charter invokes objective XX of the Constitution of Uganda, which provides that the state "shall take all practical measures to ensure the provision of basic medical services to the population,"<sup>143</sup> and frames the Charter as part of an effort to "progressively realiz[e] the right to Health."<sup>144</sup> The introduction states that "[t]his charter provides a basis for a legal and regulatory framework in health that contributes to improved capacity for quality health care."<sup>145</sup> The Charter thus arguably has—and is intended to have—some degree of legal force, given that its authority appears to be derived from the Constitution and the document itself states that the rights contained therein "shall come into force three months from the date of publication."<sup>146</sup>

The Charter addresses patients' rights and responsibilities, as well as the responsibilities of health workers, defined to include all health professionals and administrative and support staff employed in the health service.<sup>147</sup> Under the Charter, patients have the right to medical care, which includes the right to "impartial access to treatment in accordance with regulations, conditions



and arrangements obtaining at any given time in the government health care system.”<sup>148</sup> Given that the *National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights* are government-issued regulations pertaining to reproductive health service delivery, this article guarantees patients “impartial access” to comprehensive abortion care on the grounds outlined in the guidelines. [See Government Policies Section.]

The right to medical care also encompasses the right “to receive emergency medical care unconditionally in any health facility without having to pay any deposits of fees prior to medical care.”<sup>149</sup> This provision is particularly important given that patients, even those in emergency situations, such as women seeking post-abortion care, are sometimes turned away from health care facilities if they cannot pay for the care. Although all care is supposed to be free in Uganda’s public health sector,<sup>150</sup> user fees and fees for medical supplies, tests, registration, and medication are frequently levied.<sup>151</sup> For example, according to one obstetrician/gynaecologist at Mulago Hospital, his department does not charge patients for services, but it does charge patients for lab work, drugs, and scans.<sup>152</sup> Moreover, patients may be forced to pay bribes to obtain care<sup>153</sup>—including to be put on theatre lists when a surgical operation is required.<sup>154</sup> Consequently, patients, including women suffering post-abortion complications, may be turned away from hospitals if they are unable to pay the charges<sup>155</sup> or detained in health care facilities for inability to pay their medical bills after receiving care.<sup>156</sup> A provision unconditionally guaranteeing access to emergency services is an important protection for women seeking emergency post-abortion care or abortion services.

The Charter also mandates that medical facilities refer, “to the best of their facility,” any patients they cannot treat to another location where the patients can receive “appropriate medical care.”<sup>157</sup> This obligation to refer instils a duty upon the medical facility itself; the duty to refer enshrined in the professional codes of conduct applies solely to the applicable health care professional. Similarly, the Charter prohibits discrimination against patients by both the health facility and the health provider on grounds of disease, sex, age, and social status, among others.<sup>158</sup>

The Charter further guarantees the right to proper medical care, which entitles the patient to “appropriate health care with regard to both its professionalism and quality assurance based on clinical need.”<sup>159</sup> This offers patients protections against abusive practices by health care professionals—a not uncommon occurrence in the context of abortion-related services—and makes clear that patients have a right to quality care. This may offer patients an avenue for redress against facilities that do not staff providers trained in abortion and post-abortion care or that do not adequately train their providers to offer these services. Bolstering such claims is the Charter’s related “right to safety and security,” which applies “to the extent that the practices . . . of the health facility do no harm.”<sup>160</sup>

Informed consent is also strongly protected under the Charter. Patients have

*the right to be given adequate and accurate information about the nature of [their] illness, diagnostic procedures, the proposed treatment for [them] to make a decision that affects any one of these elements. The information shall be communicated to the patient at the earliest possible stage in a manner that he/she is expected to understand in order to make a free informed, and independent choice.*<sup>161</sup>

Arguably, for this choice to be informed, the patient must be comprehensively counselled on the options available to her, which would include termination of pregnancy for those patients who qualify under Uganda's laws and policies.

The Charter also affirms patients' "right to privacy in the course of consultation and treatment" and their right to confidentiality regarding the disclosure of medical information and information pertaining to treatment.<sup>162</sup> Such information may be disclosed only with the patient's informed consent or in certain enumerated circumstances.<sup>163</sup>

Finally, the Charter provides for a right to redress for violations of the rights contained therein.<sup>164</sup> Any health worker found to have violated these rights may face disciplinary sanction from "Health Unit Management committees, Health Professional Councils, Medical Boards, and Courts of law."<sup>165</sup>

# WHAT DO UGANDAN GOVERNMENT POLICIES SAY ABOUT TERMINATION OF PREGNANCY?

## IN SUMMARY:

- **The Ugandan Government has affirmed the importance of access to safe termination of pregnancy services and has issued guidelines specifying who can obtain such services. The 2006 *National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights* provide for access to these services for women living with HIV/AIDS and in cases of severe maternal illness; severe foetal abnormalities; cervical cancer; and rape, incest, and defilement.<sup>166</sup>**
- **Under these guidelines, mid-level providers can offer termination of pregnancy and post-abortion care services.<sup>167</sup>**
- **No law, policy, or regulation in Uganda requires a woman to obtain her husband's consent before receiving reproductive health services, including a termination of pregnancy.<sup>168</sup>**

The Ministry of Health has published two key abortion-related policy documents that shed light on how the abortion law is understood and interpreted by the Government of Uganda: (1) national guidelines pertaining to sexual and reproductive health and (2) a national standardized curriculum for providers on sexual and gender-based violence. Although these documents do not have the force of law, they do have evidentiary value and could be persuasive evidence in a court of law of the government's understanding of the abortion law.

## **National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights**

The most significant and primary government policy that comprehensively addresses abortion service provision in Uganda is the Ministry of Health's 2006 *National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights*<sup>169</sup> [hereinafter *National SRH Guidelines*]. The Ministry of Health issued these guidelines "to provide explicit direction and focus, as well as to streamline the training and provision of reproductive health services."<sup>170</sup> The introduction explains that the guidelines "spell out the general rules and regulations governing reproductive health services" and "identifies those eligible for . . . services [and] who will provide what services."<sup>171</sup>

The guidelines serve multiple purposes. They are meant to be used by service managers and providers to “identify types of services to be provided at each level and how to organize them to meet the established standards” and by trainers at all levels to set appropriate training targets and priorities.<sup>172</sup> The Reproductive Health Division of the Ministry of Health, in collaboration with the Human Resource Division and training institutes, is responsible for “ensur[ing] that adequate numbers of health workers are appropriately qualified and skilled to provide a full range of health services.”<sup>173</sup> Finally, the guidelines specify that they “shall be used to monitor and evaluate service availability, accessibility, quality and utilisation.”<sup>174</sup> Specifically, the Ministry of Health and other stakeholders are charged with monitoring implementation of this policy and were tasked with providing annual progress reports between 2006 and 2011.<sup>175</sup> There is thus a clear framework for holding the Ministry of Health accountable to the service standards and policy guidelines outlined in this document.

The *National SRH Guidelines* provide a robust and comprehensive definition of reproductive health and rights. Under the guidelines, “[r]eproductive health is a state of complete physical, mental, emotional and social well-being in all matters related to the reproductive system, its functions and processes.”<sup>176</sup> It implies “the capability to reproduce and the freedom to decide if, when and how often to do so.”<sup>177</sup> Reproductive rights encompass “human rights that are already recognized in international human rights documents and national laws.”<sup>178</sup> They include

*the right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children; the right to information regarding sexual and reproductive health; the right to attain the highest standard of sexual and reproductive health; [and] the [r]ight to make decisions concerning reproduction [ . . . ] free of discrimination, coercion and violence.*<sup>179</sup>

Abortion and post-abortion care are discussed under the umbrella of “comprehensive abortion care services.” According to the policy guidelines, this type of service “is health care provided to a woman or a couple seeking advice and services either for terminating a pregnancy or managing complications arising from an abortion.”<sup>180</sup> The guidelines then directly address the circumstances under which safe abortion services should be made available, providing clear guidance on how to interpret the abortion law’s life exception:

***People who can get services for termination of pregnancy:***

- ***severe maternal illnesses threatening the health of a pregnant woman e.g. severe cardiac disease, renal disease, severe pre-eclampsia and eclampsia;***
- ***severe foetal abnormalities which are not compatible with extra-uterine life e.g. molar pregnancy, anencephaly;***
- ***cancer cervix;***
- ***HIV-positive women requesting for termination;***
- ***Rape, incest and defilement.***<sup>181</sup>

It is unclear whether this is meant to be a list of illustrative examples or an exhaustive list of grounds upon which a woman may obtain a termination of pregnancy.

The policy guidelines further outline the level of facility in which terminations may be performed<sup>182</sup> and what cadre of health worker can perform them.<sup>183</sup> A medically induced abortion can be performed in a general hospital, referral hospital, or a Health Centre IV (HC IV) facility by a midwife, nurse, clinical officer, medical officer, or gynaecologist/surgeon; a surgically induced abortion can be performed only in a general or referral hospital and must be done by a gynaecologist/surgeon.<sup>184</sup> According to one gynaecologist who helped draft the guidelines, “gynaecologist/surgeon” means simply a gynaecologist who has training in surgery—something all qualified gynaecologists in Uganda have as part of their studies.<sup>185</sup> Medically induced refers to an abortion induced with the use of drugs, such as misoprostol; surgically induced indicates an abortion performed through the use of an MVA or D&C procedure, or any type of surgical intervention.

The guidelines define post-abortion care as

*health care given to a woman who has had an abortion of any cause. The care, to be provided on a 24-hour basis, is to be an integral part of SRH services. The services are to be provided in all health facilities equipped to handle the service. These facilities should observe the patients’ rights.*<sup>186</sup>

Although the guidelines state that any appropriately equipped facility can offer post-abortion care, they also delineate that evacuation for incomplete abortion can be done in a Health Centre II–III (HC II–III) facility, HC IV facility, general hospital, or referral hospital.<sup>187</sup> Further, midwives, nurses, clinical officers, medical officers, and gynaecologists may all offer evacuation for incomplete abortion and post-abortion family planning services.<sup>188</sup>

The priority groups for post-abortion care under the guidelines are “adolescents[,] women with repeated abortions who need contraception[, and] women with repeated abortions who desire to have babies.”<sup>189</sup> The guidelines also address consent for post-abortion care services, explaining that “[w]ritten or appropriate consent should be obtained from the patient or legal guardian for: evacuation for incomplete abortion; examination under general anaesthesia; [and] any surgical interventions. For a patient whose physical condition does not enable her to give a written consent, the procedure should be performed to save life.”<sup>190</sup>

Finally, the guidelines address sexual and gender-based violence service standards. Specifically, they permit midwives, nurses, clinical officers, medical officers, and gynaecologists/surgeons to offer termination of pregnancy services in cases where the pregnancy results from rape, incest, or defilement.<sup>191</sup> In this context, the guidelines do not distinguish between medically induced and surgically induced abortions, permitting these same health care providers to offer surgical interventions.<sup>192</sup> **An argument could therefore be made that these health workers may offer both medical and surgical abortion services in the sexual violence context.** Under the sexual and gender-based violence section of the guidelines, termination of pregnancy may be offered in general and referral hospitals, and surgical interventions may be offered in HC II–III and IV facilities and in general and referral hospitals.<sup>193</sup>

## THE GUIDELINES IN PRACTICE: “MOST PEOPLE DON'T KNOW ABOUT THE POLICY”<sup>194</sup>

Very few health care providers and regulators seem to have heard of, or ever seen a copy of, the *National SRH Guidelines*. Access to these guidelines is extremely limited—the Reproductive Health Division at the Ministry of Health did not have a single copy available for distribution as of late 2010, and obtaining a hard copy of the guidelines for our research required a sustained and persistent effort. As a result, and understandably, many providers cannot identify all the permitted grounds for termination of pregnancy listed in the guidelines.

### Management of Sexual and Gender Based Violence Survivors

In addition to the *National SRH Guidelines*' provision for termination of pregnancy on grounds of rape, incest, and defilement,<sup>196</sup> the Ministry of Health's 2007 handbook *Management of Sexual and Gender Based Violence Survivors* [hereinafter *SGBV Handbook*] reinforces the availability of abortion services for survivors of sexual violence in Uganda. The *SGBV Handbook* is a national, standardized curriculum designed for use in pre-service and in-service training for nurses, midwives, clinical officers, medical officers, and other health professional trainees in the management of survivors of sexual and gender-based violence.<sup>197</sup>

The *SGBV Handbook* discusses “the relationship between human rights and medical care of survivors.”<sup>198</sup> The handbook identifies rape as a human rights violation and emphasizes the importance of providers respecting the human rights of people who have been raped, including their rights to health, dignity, non-discrimination, self-determination, information, privacy, and confidentiality.<sup>199</sup> Specifically, the handbook affirms that rape survivors “have a right to receive good quality health services, including reproductive health care, management of the physical and psychological consequences of the abuse, including prevention and management of pregnancy.”<sup>200</sup>

Further, “[d]ecisions about receiving health care and treatment (e.g. emergency contraception and pregnancy termination, if the law allows) are personal ones that can only be made by the survivor[] herself. In this context, it is essential that the survivor receives appropriate information to allow her to make informed choices.”<sup>201</sup> This right to information includes the right to *complete and accurate* information: “For example, if a woman is pregnant as a result of rape, the health provider should discuss with her all the options legally available to her (e.g. keeping the child, adoption). The full range of choices must be presented regardless of the individual beliefs of the health provider, so that the survivor is able to make an informed choice.”<sup>202</sup> Finally, the confidentiality of a survivor's health information is strongly protected: “All medical and health status information related to survivors should be kept confidential and private, including from members of their family.”<sup>203</sup>

The *SGBV Handbook* then outlines the protocols to be followed for survivors of rape. If the survivor is a woman, and she presents within 72 hours of the incident, the focus is on pregnancy prevention.<sup>204</sup> The provider should offer emergency contraception, which the handbook makes clear “is a personal choice that can only be made by the woman herself. Women should be offered objective counseling on this method so as to reach an informed decision.”<sup>205</sup> Where the survivor is a child, the handbook recommends discussing emergency contraception “with her and her parent or guardian, who can help her to understand and take the regimen as required.”<sup>206</sup> However, no explicit mention is made of parental or guardian consent requirements.

If the survivor presents more than 72 hours after the incident, emergency contraception and/or an intra-uterine device may still be used to prevent pregnancy.<sup>207</sup> However, if she is pregnant as a result of the rape, she should be counselled “on the possibilities available to her.”<sup>208</sup> The *SGBV Handbook* emphasizes that pregnancy is a common concern for rape survivors and that “[e]motional support and clear information are needed to ensure that they understand the choices available to them if they become pregnant.”<sup>209</sup> The handbook also states that “[a]ll the options available, e.g. keeping the child, adoption and, where legal, abortion, should be discussed with the woman, regardless of the individual beliefs of the counsellors, medical staff or other persons involved, in order to enable her to make an informed decision.”<sup>210</sup> Depending upon whether post-exposure prophylaxis has been prescribed, the protocol notes, follow-up visits for the survivor may be scheduled at one week, two weeks, six weeks, and three months; and at each visit, the provider should assess the survivor’s pregnancy status and provide counselling consistent with that described above.<sup>211</sup>

**In this Ministry of Health handbook/curriculum, termination of pregnancy is clearly considered an option for survivors of rape.** The *SGBV Handbook* specifies that termination of pregnancy services may be provided by a midwife, nurse, clinical officer, medical officer, or gynaecologist/surgeon.<sup>212</sup> The guidelines do not distinguish between medically induced and surgically induced abortions. They also permit these same health care providers to offer surgical interventions.<sup>213</sup> An argument could therefore be made that these health workers may offer both medical and surgical termination of pregnancy services in the sexual violence context. The chart in the *SGBV Handbook* outlining who may provide services is identical to the sexual and gender-based violence chart in the *National SRH Guidelines* discussed above.<sup>214</sup>

As with the situation of the *National SRH Guidelines*, our interviews with health care professionals suggested that provisions on termination of pregnancy in the *SGBV Handbook* are not well known to providers in Uganda.

## Endnotes

- <sup>1</sup> African Charter on Human and Peoples' Rights, *adopted* June 27, 1981, O.A.U. Doc. CAB/LEG/67/3, rev. 5, 21 I.L.M. 58 (1982) (*entered into force* Oct. 21, 1986, *ratified* May 10, 1986). The Charter obliges state parties to "ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions." *Id.* art. 18(3).
- <sup>2</sup> African Charter on the Rights and Welfare of the Child, *adopted* July 11, 1990, O.A.U. Doc. CAB/LEG/24.9/49 (*entered into force* Nov. 29, 1999, *ratified* Aug. 17, 1994).
- <sup>3</sup> Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, *adopted* July 11, 2003, 2nd African Union Assembly, Maputo, Mozambique (*ratified* July 22, 2010).
- <sup>4</sup> International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, 21<sup>st</sup> Sess., Supp. No. 16, at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976, *acceded* June 21, 1995).
- <sup>5</sup> International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, 21<sup>st</sup> Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3 (*entered into force* Jan. 3, 1976, *acceded* Jan. 21, 1987).
- <sup>6</sup> Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34<sup>th</sup> Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981, *ratified* July 22, 1985).
- <sup>7</sup> Convention on the Rights of the Child, *adopted* Nov. 20, 1989, G.A. Res. 44/25, annex, U.N. GAOR, 44<sup>th</sup> Sess., Supp. No. 49, at 166, U.N. Doc. A/44/49 (1989) (*entered into force* Sept. 2, 1990, *ratified* Aug. 17, 1990).
- <sup>8</sup> Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *adopted* Dec. 10, 1984, G.A. Res. 39/46, U.N. GAOR, 39<sup>th</sup> Sess., Supp. No. 51, at 197, U.N. Doc. A/39/51 (1984), 1465 U.N.T.S. 85 (*entered into force* June 26, 1987, *acceded* Nov. 3, 1986).
- <sup>9</sup> Vienna Convention on the Law of Treaties, art. 2.1(b), May 23, 1969, 1155 U.N.T.S. 331, 8 I.L.M. 679 (*entered into force* Jan. 27, 1980) [hereinafter Vienna Convention]; *see also* Vienna Declaration and Programme of Action, World Conference on Human Rights, para. 1, Vienna, Austria, July 14–25, 1993, U.N. Doc. A/CONF 157/23 (1993) (reaffirming "the solemn commitment of all States to fulfil their obligations to promote universal respect for, and observance and protection of, all human rights and fundamental freedoms for all in accordance with the Charter of the United Nations, other instruments relating to human rights, and international law").
- <sup>10</sup> OFFICE OF THE HIGH COMMISSIONER FOR HUMAN RIGHTS, UGANDA AND THE UNITED NATIONS HUMAN RIGHTS MECHANISMS 19–20 (2008) ("[The Ratification of Treaties] Act requires all ratified treaties to be laid before Parliament as soon as possible. While it is not mentioned what Parliament should then do with the treaties, the logical deduction is that this process is for the purposes of giving the treaty domestic legal effect. . . . This process has taken two forms; either through adopting the whole text of the international treaty as a schedule to the domesticating Act . . . or, alternatively, through the transformation of the provisions of the treaty into provisions of an Act of Parliament, sometimes redrafted guided by the spirit of the treaty."), *available at* <http://www.ohchr.org/Documents/Countries/PublicationUgandaUNHRMechanisms.pdf>.
- <sup>11</sup> Vienna Convention, *supra* note 9, art. 27.
- <sup>12</sup> CONSTITUTION, objective XXVIII(i)(b) (1995).
- <sup>13</sup> Attorney General v. Susan Kigula & 417 Ors Constitutional Appeal No 03 of 2006, ILDC 1260, *cited in* Interights, Selected International Standards and Case-Law: Litigation Surgery on the Right to Education in Africa 64 (Mar. 12–15, 2012).
- <sup>14</sup> *Id.*
- <sup>15</sup> Tinyefuza v. Attorney General, Constitutional Petition 1 of 1996 (unreported), *cited in* Interights, Selected International Standards and Case-Law: Litigation Surgery on the Right to Education in Africa 64 (Mar. 12–15, 2012).
- <sup>16</sup> *See, e.g.*, Constitutional Court of Uganda, Constitutional Petition No. 8 of 2007 (July 28, 2010) (ruling that the practice of female genital mutilation is inconsistent with the Constitution of Uganda and in violation of international treaties to which Uganda is a party).
- <sup>17</sup> Programme of Action of the International Conference on Population and Development, Cairo, Egypt, Sept. 5–13, 1994, U.N. Doc. A/CONF.171/13/Rev.1 (1995); African Platform for Action of the Fifth African Regional Conference on Women, Dakar, Senegal, Nov. 16–23, 1994 (1995); Beijing Platform for Action, Fourth World Conference on Women, Beijing, China, Sept. 15, 1995, U.N. Doc. A/CONF.177/20 (1995) and A/CONF.177/20/Add.1 (1995). The consensus documents that emerged from these conferences are not legally binding on states. By setting forth a detailed, global mandate, however, these documents contribute to advancing and interpreting the human rights standards contained in human rights treaties.
- <sup>18</sup> UNITED NATIONS, THE MILLENNIUM DEVELOPMENT GOALS REPORT 6–9, 12–13 (2006), *available at* <http://unstats.un.org/unsd/mdg/Resources/Static/Products/Progress2006/MDGReport2006.pdf>.
- <sup>19</sup> Ministry of Foreign Affairs, AOG 238/01, Instrument of Ratification Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (July 21, 2010) (on file with the Center).
- <sup>20</sup> The other countries are Kenya, Swaziland, and Zambia.
- <sup>21</sup> CONSTITUTION, art. 22(2) (1995).
- <sup>22</sup> Penal Code Act, Cap. 120, secs. 141–43.
- <sup>23</sup> *Id.* sec. 212.
- <sup>24</sup> *See id.* secs 187, 188, 211, 213—creating the crimes of manslaughter, murder, concealing a born child, and infanticide, applicable only to a born child or person.
- <sup>25</sup> *See also* Magistrates Courts Act, Cap. 16, sec. 148 (1971), for evidence of this continuum in the criminal law.
- <sup>26</sup> Penal Code Act, Cap. 120, sec. 212.
- <sup>27</sup> *Id.* secs. 141–42.
- <sup>28</sup> Critically, article 22(2) of the Constitution uses the term "law" as opposed to "written law." This could be understood to mean that the constitutional drafters intended the "authorized by law" language to have a broader meaning and to include "the common law" (*see* Judicature Act, Cap. 13, sec. 14 (1996)) or applicable case law in addition to legislation. This is significant for the weight given to *Rex v. Bourne*, an important common-law abortion case from the United Kingdom, in which the judge found that a life exception in the United Kingdom's Infant Life (Preservation) Act of 1929—similar to the life exception in section 224 of the Ugandan Penal Code—applied broadly to terminations done at all stages of pregnancy and further comprised an exception for mental and physical health. [*See* Case Law Section.].
- <sup>29</sup> Interpretation Act, Cap. 3, sec. 2(vv) (1976).
- <sup>30</sup> Penal Code Act, Cap. 120, sec. 224.
- <sup>31</sup> CONSTITUTION, objective XIV(b) (1995).
- <sup>32</sup> *Id.* objective XX.
- <sup>33</sup> The Ugandan Constitutional Commission, charged with collecting public views on the Constitution and making suggestions for a new constitution, stated clearly that the public wanted constitutional protections for economic and social rights. However, fear of financial or economic inability to protect and promote such rights led the Commission to "find it prudent not to make them enforceable rights. Nevertheless," said the Commission, "provision of such rights in a non-enforceable form will set vitally important directions for future policy and programmes of government." OFFICE OF THE HIGH COMMISSIONER FOR HUMAN RIGHTS, *supra* note 10, at 21 (citing Republic of Uganda, Report of the Uganda Constitutional Commission: Analysis and Recommendations, para. 23.85, at 651).
- <sup>34</sup> CONSTITUTION, objective I(i) (1995).
- <sup>35</sup> DEPARTMENT OF QUALITY ASSURANCE, MINISTRY OF HEALTH, PATIENTS' CHARTER 1 (Dec. 2009) [hereinafter PATIENTS' CHARTER].



36 Constitution (Amendment) Act, sec. 4 (2005), available at <http://www.law.georgetown.edu/RossRights/documents/RossUgandaConstitutionAmend2005.pdf>.

37 OFFICE OF THE HIGH COMMISSIONER FOR HUMAN RIGHTS, *supra* note 10, at 21.

38 *Id.* (citing C. Mbazira, *Public Interest Litigation and Judicial Activism in Uganda: Improving the Enforcement of Economic and Social Rights* (HURIPPEC Working Paper 24, forthcoming)).

39 *Id.*

40 *Id.* at 22.

41 CONSTITUTION, art. 34(3) (1995).

42 *Id.* art. 24.

43 See CENTER FOR REPRODUCTIVE RIGHTS, REPRODUCTIVE RIGHTS VIOLATIONS AS TORTURE AND CRUEL, INHUMAN, OR DEGRADING TREATMENT OR PUNISHMENT: A CRITICAL HUMAN RIGHTS ANALYSIS 21–24 (2011).

44 Constitution (Amendment) Act, sec. 11 (2005) (amending article 32(2)).

45 CONSTITUTION, art. 33 (1995); see also Constitution (Amendment) Act, sec. 12 (2005) (amending article 33).

46 CONSTITUTION, art. 27(2) (1995).

47 *Id.* art. 41(1).

48 See *id.*; see also Access to Information Act, sec. 21 (2005).

49 CONSTITUTION, art. 45 (1995).

50 Although this is the only substantive reference, the Magistrates Courts Act does set forth key procedural guidance for magistrate's courts in charging and convicting an individual for the crimes of unlawful abortion, killing an unborn child, manslaughter, infanticide, and concealing a born child. Essentially, if a person is charged with a crime but the court is of the opinion that the defendant should have been charged with a different, but related, crime, then the defendant may be convicted of that offence even though the defendant was not originally charged with it. Magistrates Courts Act, Cap. 16, sec. 148 (1971).

51 Penal Code Act, Cap. 120, secs. 141–43.

52 See discussion in the Case Law Section on *Rex v. Bourne* and *Mehar Singh Bansel v. R.*

53 Although there may be a medical definition or understanding of the terms “abortion” or “miscarriage,” it is important to distinguish any medical definition from a legal definition. Under Ugandan law, there is no legal definition of these terms.

54 Penal Code Act, Cap. 120, sec. 197.

55 *Id.* sec. 212.

56 Under the Penal Code, the crime of infanticide applies only to a woman who, with the requisite mental state, “causes the death of her child being a child under the age of twelve months.” *Id.* sec. 213. In such a case, the woman would be punished as though she had been guilty of manslaughter, as opposed to murder. All others complicit in the killing of a “born child” would be accused of murder or manslaughter.

57 LILLIAN TIBATEMWA-EKIRIKUBINZA, OFFENCES AGAINST THE PERSON: HOMICIDES AND NON-FATAL ASSAULTS IN UGANDA 128 (2005).

58 Penal Code Act, Cap. 120, sec. 212.

59 TIBATEMWA-EKIRIKUBINZA, *supra* note 57, at 128.

60 REBECCA J. COOK & BERNARD M. DICKENS, EMERGING ISSUES IN COMMONWEALTH ABORTION LAWS 14 (1982) [hereinafter COOK & DICKENS, EMERGING ISSUES] (on file with the Center).

61 The Infant Life (Preservation) Act was passed in 1929 to provide for the case the judge referred to in *Bourne*. Section 212 was added to the Ugandan Penal Code in 1935 (Ordinance No. 17 of 1935), so it is reasonable to believe that its inclusion in the Penal Code stemmed from the debate surrounding, and passage of, the 1929 Act in the United Kingdom and that it was meant to achieve a similar end.

62 *Charge of Procuring Abortion: Rex v. Bourne*, BRITISH MEDICAL JOURNAL, July 23, 1938, at 201.

63 *Id.*

64 CONSTITUTION, art. 22(2) (1995) (emphasis added).

65 Penal Code Act, Cap. 120, sec. 224.

66 REBECCA J. COOK & BERNARD M. DICKENS, ABORTION LAWS IN COMMONWEALTH COUNTRIES 22 (1979) [hereinafter COOK & DICKENS, ABORTION LAWS].

67 *Id.* at 16.

68 *Id.* at 17.

69 *Id.* at 18.

70 *Id.* at 60.

71 *Id.* at 18.

72 *Id.* at 22.

73 *Id.* at 60.

74 Notably, section 202 of the Ugandan Penal Code exempts a person from this requirement in cases of necessity, where the woman's life or health is in danger. Penal Code Act, Cap. 120, sec. 202.

75 The World Health Organization has made clear that mid-level providers can safely and beneficially provide first-trimester abortion services. See Marge Berer, *Provision of Abortion by Mid-Level Providers: International Policy, Practice and Perspectives*, 87 BULLETIN OF THE WHO 58 (2009).

76 CONSTITUTION, art. 22(2) (1995).

77 COOK & DICKENS, EMERGING ISSUES, *supra* note 60, at 14 (emphasis added).

78 GLANVILLE WILLIAMS, THE SANCTITY OF LIFE AND THE CRIMINAL LAW 164 (1958) [hereinafter WILLIAMS, THE SANCTITY OF LIFE].

79 Letter from Dr. S.L.D. Muyanga for the Permanent Secretary, Ministry of Health, to Dr. K.G. Mather, Chief Executive Officer, Medical Section (Oct. 18, 1976) (on file with the Center).

80 P.K. Asiimwe for the Solicitor General, ADM/7/161/01, Re: Seeking Guidance on the Legal Definition of Abortion in Uganda, sec. 3.4, (May 7, 2002) (on file with the Center).

81 REPRODUCTIVE HEALTH DIVISION, MINISTRY OF HEALTH, NATIONAL POLICY GUIDELINES AND SERVICE STANDARDS FOR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS 45 (2006) [hereinafter NATIONAL SRH GUIDELINES]; MINISTRY OF HEALTH, MANAGEMENT OF SEXUAL AND GENDER BASED VIOLENCE SURVIVORS 49 (Apr. 2007) [hereinafter SGBV HANDBOOK]; MINISTRY OF HEALTH, NATIONAL TRAINING CURRICULUM FOR HEALTH WORKERS ON ADOLESCENT HEALTH AND DEVELOPMENT: TRAINEE HAND BOOK 157 (2001) [hereinafter NATIONAL TRAINING CURRICULUM ON ADOLESCENT HEALTH].

82 Interview with His Worship Vincent Emmy Mugabo, Chief Magistrate (May 31, 2011).

83 A May 2011 search of the records database of the Chief Magistrate's Court in Kampala revealed only one abortion-related case, *Uganda v. Dr. S. Nawabul Hassan and Sebakaki Kenneth*, in which a doctor was found guilty of attempting to procure an unlawful abortion under section 141. *Uganda v. Dr. S. Nawabul Hassan and Sebakaki Kenneth*, Chief Magistrate's Court – Kampala (2008). The woman in that case had died from complications from the unsafe abortion. Interestingly, the doctor in this case was the woman's boyfriend, though he did not perform the abortion himself. According to the judgment, the “unsafe abortion” was performed “at a clinic in Old Kampala.” *Id.* at 7. Nonetheless, the doctor was convicted under section 141 for procuring an abortion because (1) he “paid for the unlawful service” and (2) after the woman sought post-abortion care and did not improve, he “started administering drugs including IV fluids,” which, according to the magistrate, “was also unlawful with a clear motive of terminating the pregnancy.” *Id.* at 7, 9. The person who performed the unsafe abortion at the clinic in Old Kampala, who was also the owner of the clinic, was found guilty of manslaughter. *Id.* at 16.

84 See interview with Eva Luswata, Ugandan Lawyer in Private Practice (Sept. 20, 2010) (“We use English precedent as far back as 1890. A lot of reverence is given to UK case law, both new and old. So it would definitely have weight to refer to *Rex v. Bourne*”); see also interview with Winfred Nabisinde, Ugandan Lawyer and Former Magistrate (Sept. 21, 2010).

85 *Rex v. Bourne*, [1939] 1 K.B. 687.

86 *Id.*

87 See COOK & DICKENS, ABORTION LAWS, *supra* note 66, at 13.

88 *Bourne* was a criminal case, tried before a jury. As such, there is no reasoning provided for the final verdict; rather, the legal reasoning is found in the judge's written summing-up to the jury, in which the judge is tasked with explaining points of law and summarizing relevant evidence given at trial.

89 Infant Life (Preservation) Act, ch. 34, sec. 1(1) (1929).

90 COOK & DICKENS, EMERGING ISSUES, *supra* note 60, at 14.

91 *Bourne*, 1 K.B. at 691.

92 P.K. Asiimwe for the Solicitor General, No. ADM/7/161/01, Re: Seeking Guidance on the Legal Definition of Abortion in Uganda, sec. 1.0 (May 7, 2002) (on file with the Center).

- <sup>93</sup> Section 224 of the Ugandan Penal Code (then called section 201A) was passed into law by ordinance in 1935—six years after the 1929 Infant Life (Preservation) Act debate and enactment in the United Kingdom—and its introduction was likely an effort to mirror legal developments in the United Kingdom. UGANDA PROTECTORATE, ORDINANCES AND SUBSIDIARY LEGISLATION, No. 17 of 1935—Penal Code (Amendment) Ordinance (Oct. 15, 1935).
- <sup>94</sup> *Bourne*, 1 K.B. at 692.
- <sup>95</sup> *Id.*
- <sup>96</sup> *Id.* at 693 (emphasis added).
- <sup>97</sup> *Id.* at 694.
- <sup>98</sup> See *supra* note 75.
- <sup>99</sup> *Bourne*, 1 K.B. at 695.
- <sup>100</sup> *Id.* at 694.
- <sup>101</sup> *Id.*
- <sup>102</sup> CONSTITUTION, art. 31(1) (1995).
- <sup>103</sup> *Bourne*, 1 K.B. at 694.
- <sup>104</sup> COOK & DICKENS, ABORTION LAWS, *supra* note 66, at 13.
- <sup>105</sup> *Alleged Conspiracy to Procure Miscarriages: Two Doctors Acquitted*, BRITISH MEDICAL JOURNAL, May 22, 1948, at 1008.
- <sup>106</sup> *Id.*
- <sup>107</sup> *Id.*
- <sup>108</sup> *Criminal Abortion and Manslaughter: Five-Year Sentence on Doctor*, BRITISH MEDICAL JOURNAL, May 24, 1958, at 1242.
- <sup>109</sup> *Id.* at 1247.
- <sup>110</sup> *Id.*
- <sup>111</sup> See, for example, *R. v. Edgal*, 4 W.A.C.A. 133 (1938) (West African Court of Appeal, Southern States, Nigeria), *cited in* COOK & DICKENS, ABORTION LAWS, *supra* note 66, at 13; *People v. Gulshan, Smith and Finlayson*, (1971) High Court [Criminal] HP. 11/1971 (Zambia), *cited in* COOK & DICKENS, ABORTION LAWS, *supra* note 66, at 14; *Mehar Singh Bansel v. R.*, [1959] E. Afr. L. Rep. 813 (East African Court of Appeal, Kenya); *R. v. Morgentaler*, (1976) 64 D.L.R. (3d) 718 (Quebec, Canada), *cited in* COOK & DICKENS, ABORTION LAWS, *supra* note 66, at 14; *R. v. Davidson*, [1969] V.R. 667 (Supreme Court of Victoria, Australia), *cited in* COOK & DICKENS, ABORTION LAWS, *supra* note 66, at 13; *R. v. Anderson*, [1951] N.Z.L.R. 439 (New Zealand), *cited in* COOK & DICKENS, ABORTION LAWS, *supra* note 66, at 14.
- <sup>112</sup> *Mehar Singh Bansel v. R.*, [1959] E. Afr. L. Rep. 813, 832.
- <sup>113</sup> *Id.*
- <sup>114</sup> COOK & DICKENS, ABORTION LAWS, *supra* note 66, at 5.
- <sup>115</sup> Letter from Dr. S.L.D. Muyanga for the Permanent Secretary, Ministry of Health, to Dr. K.G. Mather, Chief Executive Officer, Medical Section (Oct. 18, 1976) (on file with the Center).
- <sup>116</sup> *Id.* (attaching questionnaire).
- <sup>117</sup> P.K. Asimwe for the Solicitor General, ADM/7/161/01, Re: Seeking Guidance on the Legal Definition of Abortion in Uganda, sec. 3.4 (May 7, 2002) (on file with the Center).
- <sup>118</sup> See interview with Eva Luswata, Ugandan Lawyer in Private Practice (Sept. 20, 2010); see also interview with Winfred Nabisinde, Ugandan Lawyer and Former Magistrate (Sept. 21, 2010).
- <sup>119</sup> Interview with Eva Luswata, Ugandan Lawyer in Private Practice (Sept. 20, 2010).
- <sup>120</sup> World Health Organization, Constitution of the World Health Organization, signed July 22, 1946, pmbi. (entered into force April 7, 1948).
- <sup>121</sup> WILLIAMS, THE SANCTITY OF LIFE, *supra* note 78, at 170; GLANVILLE WILLIAMS, TEXTBOOK OF CRIMINAL LAW 302 (2d ed. 1983).
- <sup>122</sup> See GUTTMACHER INSTITUTE, ABORTION WORLDWIDE: A DECADE OF UNEVEN PROGRESS 24, 29, 31 (2009); CENTER FOR REPRODUCTIVE RIGHTS, IN HARM'S WAY: THE IMPACT OF KENYA'S RESTRICTIVE ABORTION LAW 60–63 (2010); GABRIEL JAGWE-WADDA ET AL., GUTTMACHER INSTITUTE, ABORTION MORBIDITY IN UGANDA: EVIDENCE FROM TWO COMMUNITIES 41 (2006).
- <sup>123</sup> The relevant acts are the Medical and Dental Practitioners Act, Cap. 272 (1998); Allied Health Professionals Act Cap. 268 (1996); Nurses and Midwives Act, Cap. 274 (1996); Pharmacy and Drugs Act, Cap. 280 (1971). See *infra* note 123 for relevant codes of conduct.
- <sup>124</sup> The codes examined include the Professional Code of Conduct and Ethics for Medical and Dental Practitioners (2009); Allied Health Professionals Council: Code of Conduct and Ethics for Allied Health Professionals (2009); Uganda Nurses and Midwives Council: Professional Code of Conduct and Ethics for Nurses and Midwives 1 (2009); Uganda Nurses and Midwives Council: Professional Code of Conduct and Ethics for Medical and Dental Practitioners 2 (2009); Allied Health Professionals Council: Code of Conduct and Ethics for Allied Health Professionals 3 (2009); Uganda Nurses and Midwives Council: Professional Code of Conduct and Ethics for Nurses and Midwives 1, 5, 12 (2009).
- <sup>125</sup> See text box for more information on this perceived “requirement.”
- <sup>126</sup> WILLIAMS, THE SANCTITY OF LIFE, *supra* note 78, at 170.
- <sup>127</sup> WILLIAMS, TEXTBOOK OF CRIMINAL LAW, *supra* note 121, at 302.
- <sup>128</sup> Abortion Act, 1967, sec. 1(1) (U.K.).
- <sup>129</sup> Interview with Obstetrician/Gynaecologist (Sept. 17, 2010).
- <sup>130</sup> Interview with members of regulatory body (Jan. 18, 2011).
- <sup>131</sup> Interview with Obstetrician/Gynaecologist (Sept. 20, 2010).
- <sup>132</sup> This is based on our research but is also confirmed in an interview with Dr. Winfred Nabisinde, Ugandan Lawyer and Former Magistrate (Sept. 21, 2010). See also Maria Nassali, *Legal Assessment: Uganda* 42 (2010).
- <sup>133</sup> Research revealed only one written reference to this practice in any health-related government documents. The Ministry of Health’s 2001 *National Training Curriculum on Adolescent Health*, in its module on abortion and related complications, explains the abortion law in Uganda as follows: “[A]bortion is illegal except where there is a medical indication necessitating an abortion in order to save the life of the mother. Even when abortion is contemplated due to medical reasons, the presence of an obstetrician/gynaecologist and a psychiatrist must be sought.” The trainee handbook cites no source for this interpretation of the abortion law. NATIONAL TRAINING CURRICULUM ON ADOLESCENT HEALTH, *supra* note 81, at 144.
- <sup>134</sup> SCIENCE AND TECHNOLOGY COMMITTEE, HOUSE OF COMMONS, SCIENTIFIC DEVELOPMENTS RELATING TO THE ABORTION ACT 1967: TWELFTH REPORT OF SESSION 2006–07, para. 99 (2007), available at <http://www.publications.parliament.uk/pa/cm200607/cmselect/cmsctech/1045/1045i.pdf>.
- <sup>135</sup> In its report, the committee of experts stated, “The requirement that abortion could be performed by medical practitioners alone [ ] raised concerns. It would mean that women in poor rural communities without such services would be unable procure abortions with potentially serious or fatal repercussions for some poor women.” COMMITTEE OF EXPERTS ON CONSTITUTIONAL REVIEW, FINAL REPORT OF THE COMMITTEE OF EXPERTS ON CONSTITUTIONAL REVIEW 111 (2010), available at [http://www.ldphs.org.za/resources/local-government-database/by-country/kenya/commission-reports/CoE\\_final\\_report.pdf](http://www.ldphs.org.za/resources/local-government-database/by-country/kenya/commission-reports/CoE_final_report.pdf).
- <sup>136</sup> CENTER FOR REPRODUCTIVE RIGHTS, CRAFTING AN ABORTION LAW THAT RESPECTS WOMEN’S RIGHTS: ISSUES TO CONSIDER 1–3 (2004).
- <sup>137</sup> Professional Code of Conduct and Ethics for Medical and Dental Practitioners 2 (2009); Allied Health Professionals Council: Code of Conduct and Ethics for Allied Health Professionals 3 (2009); Uganda Nurses and Midwives Council: Professional Code of Conduct and Ethics for Nurses and Midwives 1 (2009).
- <sup>138</sup> Professional Code of Conduct and Ethics for Medical and Dental Practitioners 2 (2009); Allied Health Professionals Council: Code of Conduct and Ethics for Allied Health Professionals 3 (2009); Uganda Nurses and Midwives Council: Professional Code of Conduct and Ethics for Nurses and Midwives 1, 5, 12 (2009).
- <sup>139</sup> Professional Code of Conduct and Ethics for Medical and Dental Practitioners 2 (2009); Allied Health Professionals Council:

- Code of Conduct and Ethics for Allied Health Professionals 4, 6 (2009); Uganda Nurses and Midwives Council: Professional Code of Conduct and Ethics for Nurses and Midwives 5, 6, 13 (2009).
- 140 Professional Code of Conduct and Ethics for Medical and Dental Practitioners 3 (2009); Allied Health Professionals Council: Code of Conduct and Ethics for Allied Health Professionals 4 (2009); Uganda Nurses and Midwives Council: Professional Code of Conduct and Ethics for Nurses and Midwives 6 (2009).
- 141 Pharmacy Council of Uganda: Professional Code of Conduct and Ethics for Pharmacists in Uganda 4, 5 (2009).
- 142 Professional Code of Conduct and Ethics for Medical and Dental Practitioners 10–11 (2009); Allied Health Professionals Council: Code of Conduct and Ethics for Allied Health Professionals 13–14 (2009); Uganda Nurses and Midwives Council: Professional Code of Conduct and Ethics for Nurses and Midwives 22–23 (2009); Pharmacy Council of Uganda: Professional Code of Conduct and Ethics for Pharmacists in Uganda 11–12 (2009).
- 143 CONSTITUTION, objective XX (1995).
- 144 PATIENTS’ CHARTER, *supra* note 35, at 1.
- 145 *Id.*
- 146 *Id.* at 18.
- 147 *Id.* at 4.
- 148 *Id.* art. 1.
- 149 *Id.*
- 150 See UGANDA MINISTRY OF HEALTH & MACRO INTERNATIONAL INC., UGANDA SERVICE PROVISION ASSESSMENT SURVEY 2007, at 99, 118 (2008); JAGWE-WADDA ET AL., *supra* note 122, 41–42 (2006) (noting that public facilities are supposed to provide free care).
- 151 See ACTION FOR GLOBAL HEALTH, HEALTH SPENDING IN UGANDA: THE IMPACT OF CURRENT AID STRUCTURES AND AID EFFECTIVENESS 17 (2010); see also JAGWE-WADDA ET AL., *supra* note 122, at 41–42 (reporting that money is a “prerequisite” to receiving treatment at private facilities and “speeds up” and allows for “faster” treatment at public facilities); see also interview with Dr. Peter Mukasa, Obstetrician/Gynaecologist (Sept. 20, 2010) and interview with Charles Kiggundu, Obstetrician/Gynaecologist, Mulago Hospital (Sept. 17, 2010).
- 152 Interview with Charles Kiggundu, Obstetrician/Gynaecologist, Mulago Hospital (Sept. 17, 2010); see also interview with Dr. Peter Mukasa, Obstetrician/Gynaecologist (Sept. 20, 2010).
- 153 See JAGWE-WADDA ET AL., *supra* note 122, at 40–42 (observing that “money alone guarantees access to safe treatment” and that payment in public facilities “influences the kind of treatment women receive”); see also SUSHEELA SINGH ET AL., GUTTMACHER INSTITUTE, UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA: CAUSES AND CONSEQUENCES 18 (2006) (noting that “having money improves a woman’s chances of being treated well”).
- 154 Interview with Dr. Charles Kiggundu, Obstetrician/Gynaecologist, Mulago Hospital (Sept. 17, 2010).
- 155 See SINGH ET AL., *supra* note 153, at 17 (citing G. Jagwe-Wadda et al., *Community Perceptions of Abortion Morbidity in Uganda: Issues and Challenges* (Occasional Report, Guttmacher Institute, 2006)).
- 156 Interview with Robinah Kaitiritimba, National Coordinator, Uganda National Health Consumers’ Organisation (Sept. 22, 2010) (discussing having referred cases of patients being detained for their inability to pay to the Uganda Human Rights Commission and explaining that the Commission, in deciding on such a case, said that this was an illegal practice and that the facilities needed to compensate those detained). See also *Wanjala Boaz Abungu v. Registered Trustees of Mengo Hospital*, Complaint No. 620 of 1999, Uganda Human Rights Commission (2002).
- 157 PATIENTS’ CHARTER, *supra* note 35, art. 1.
- 158 *Id.* art. 2.
- 159 *Id.* art. 5.
- 160 *Id.* art. 8.
- 161 *Id.* art. 10.
- 162 *Id.* art. 15.
- 163 *Id.* These circumstances are as follows: “i. That the disclosure is for the purpose of the patient’s treatment by another health worker; ii. That disclosure of the information is vital for the protection of the health of others or the public, and that the need for disclosure overrides the interest in the information’s non-disclosure; iii. That the disclosure is for the purpose of publication in a medical journal or for research or teaching purposes if all details identifying the patient have been suppressed.” *Id.*
- 164 *Id.* art. 19.
- 165 *Id.* art. 25.
- 166 NATIONAL SRH GUIDELINES, *supra* note 81, at 45.
- 167 *Id.* at 48, tbl.3.
- 168 The absence of a spousal consent requirement is reflected in the 2006 *National SRH Guidelines*.
- 169 NATIONAL SRH GUIDELINES, *supra* note 81. We would like to thank Dr. Maria Nassali for bringing our attention to these guidelines.
- 170 *Id.* at 10.
- 171 *Id.*
- 172 *Id.* at 11.
- 173 *Id.* at 17.
- 174 *Id.* at 11.
- 175 *Id.*
- 176 *Id.* at 12.
- 177 *Id.*
- 178 *Id.*
- 179 *Id.*
- 180 *Id.* at 45.
- 181 *Id.*
- 182 *Id.* at 47, tbl. 2.
- 183 *Id.* at 48, tbl. 3.
- 184 *Id.* at 47 tbl. 2 & 48 tbl. 3.
- 185 Interview with Dr. Charles Kiggundu, Obstetrician/Gynaecologist, Mulago Hospital (May 30, 2011).
- 186 NATIONAL SRH GUIDELINES, *supra* note 81, at 46.
- 187 *Id.* at 47, tbl. 2.
- 188 *Id.* at 48, tbl. 3.
- 189 *Id.* at 46.
- 190 *Id.* at 47.
- 191 *Id.* at 77, tbl. 14.
- 192 *Id.*
- 193 *Id.* at 77, tbl. 13.
- 194 Interview with Dr. Charles Kiggundu, Obstetrician/Gynaecologist, Mulago Hospital (Sept. 17, 2010).
- 195 Interview with Dr. Olive Sentumbwe, Obstetrician/Gynaecologist and Adviser at the World Health Organization, (Sept. 24, 2010).
- 196 NATIONAL SRH GUIDELINES, *supra* note 81, at 45.
- 197 SGBV HANDBOOK, *supra* note 81, at 7.
- 198 *Id.* at 43.
- 199 *Id.* at 45–46.
- 200 *Id.* at 45.
- 201 *Id.*
- 202 *Id.* at 45–46.
- 203 *Id.* at 46.
- 204 *Id.* at 71, 73.
- 205 *Id.* at 73.
- 206 *Id.*
- 207 *Id.* at 77.
- 208 *Id.*
- 209 *Id.* at 81.
- 210 *Id.* at 82.
- 211 *Id.* at 84–85.
- 212 *Id.* at 49.
- 213 *Id.*
- 214 An additional Ministry of Health document that supports the availability of abortion services for survivors of sexual violence is the 2001 *National Training Curriculum for Health Workers on Adolescent Health and Development*. This document provides that, “[i]n the case of rape, [service providers can] offer emergency contraception if it has been less than 72 hours since the assault occurred; . . . offer a pregnancy test or refer; [and offer referral for abortion if appropriate and possible.]” NATIONAL TRAINING CURRICULUM ON ADOLESCENT HEALTH, *supra* note 81, at 157. This reinforces the policies laid out in the *SGBV Handbook* and suggests that abortion as an option for survivors of rape has been a government policy for at least the last decade.





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