Access to safe abortion in Uganda: Leveraging Opportunities through the Harm Reduction Model

Mulumba, Moses*; Kiggundu, Charlesb; Nassimbwa, Jacquelinea; and Nakibuuka, Noor Musisi*

a Center for Health, Human Rights and Development, Kampala, Uganda
b Department of Obstetrics and Gynaecology, Mulago Regional Referral Hospital, Uganda

*Plot 833, Old Kiira Road, Ntinda-Kiwatule P.O. Box 16617, Wandegeya, Kampala, Uganda Email: mulumba@cehurd.org

Synopsis
How Uganda's legal, policy and ethical environment could promote the harm reduction model in an effort to reduce complications from unsafe abortion.

Abstract
Access to safe and legal abortion services is a far reach for women and girls in Uganda. Although unsafe abortion rates have fallen from 54 to 39 per 1000 women aged 15 to 45 years over a decade, absolute figures show a rise from 294,000 in 2003 to 314,000 women having unsafe abortions in 2013. Unfortunately, only 50% of the women who develop abortion complications are able to reach facilities for post-abortion care. Despite the clinical evidence and the stories from undocumented cases, debate on access to safer and legal abortion is constricted, moralized and stigmatized. The harm reduction model has shown evidence of benefit in reducing maternal mortality and morbidity due to unsafe abortion while addressing related stigma and discrimination and advancing women's reproductive health rights. This article presents a case for promoting the model in Uganda.

Key Words
1. Abortion laws
2. Abortion policies and guidelines
3. Constitutional rights
4. Ethics
5. Harm Reduction Model
6. Human Rights
7. Ugandan abortion law
8. Unsafe abortion

1. Background on abortion in Uganda

The realization of sexual and reproductive health rights for all in Uganda still faces numerous challenges. Indicators still point to high levels of unintended pregnancies, resulting in high levels of unplanned births of undesired children and unsafe abortions [1, 2]. Access to safe and legal abortion services is a far reach for women and girls in Uganda. The laws are restrictive and there is much negative moral and social judgment related not only to unsafe sexual practices and contraceptive use, but also to safe pregnancy terminations for women and girls in most need. Although unsafe abortion rates have reduced from 54 to 39 per 1000 women aged 15 to 45 years over a decade, absolute figures show a rise in women having unsafe abortion from 294,000 in 2003 to 314,000 in 2013. The resultant contribution of close to 1200
deaths annually out of the total 6500 maternal deaths continues to exert huge costs to human life especially of young women of reproductive age [1, 2].

The total cost of post-abortion care, including medical and non-medical costs, is estimated each year at about US$14 million, for a country that could save over three quarters of that amount if women were able to access quality contraception and safer abortion methods [1, 3]. The more unfortunate reality is that the statistics on mortality and morbidity due to unsafe abortion are a reflection of only those women who are able to access care at health facilities. Studies demonstrate that only 50% of the women who develop abortion complications are able to reach facilities for a post abortion care service [3]. Nagudi Esther (pseudo names), aged 20 years, procured an abortion from an elderly woman who inserted a cassava root inside her uterus and supplemented the procedure with herbs. Esther recounts that the pregnancy was terminated but she bled for over three years with intermittent abdominal pain. She was afraid of interfacing with a health facility and therefore kept seeking help from herbalists. By the time of the interview, the bleeding had reduced but was still brought on by coughing and sneezing [4] (p 13). How many more Esthers are in the community?

Despite such stories and more clinical evidence, debate on providing a wider window for accessing safer legal abortion is constricted, moralized and stigmatized. Past policy efforts, including the development and operationalization of clinical guidelines, have been frustrated. This article describes available opportunities for activities by women and proponents of women’s rights, on accessing legal and safer abortions. Despite the fact that the laws on abortion are unclear and that health ministry guidelines are stayed, there are still ways that laws, policies and ethical guidance can be used to institute a harm reduction model to the advantage of women’s health.

2. Legal and policy environments and values

The law in Uganda codifies punishments for criminal abortion, deterring health care providers from providing lawful care in a safe environment. Their liability to punishment also deters women from seeking abortion services, including information and real pre- and post- abortion care (PAC). For most law enforcement officers, anything to do with abortion, including provision of lifesaving post-abortion care, is considered criminal and leads to arrest and incarceration, which demoralizes health workers and facilities that consequently shy away from providing lifesaving care.

Dr. Henry Kadaga, an obstetrician/ gynecologist at a Regional Referral Hospital was arrested and detained for two weeks for providing PAC to a girl who died while in his care. He did everything he could to save her life, but her relatives and the police did not understand. The midwife who assisted him during the procedure was detained for one week, and she vowed never to provide post-abortion care again [4] (p.17-18). "When the lady I was providing PAC to died, two plain clothed policemen came and arrested me. I was arrested together with my midwife. They thought I was the one who was involved in performing the initial abortion. Today when a patient comes to my clinic, they are told, 'you are going to that clinic where they killed a woman.' - Dr. Kadaga Henry"

According to the 1995 Constitution of Uganda, Art. 22(2), “No person has the right to terminate the life of an unborn child except as may be authorized by law”. However, since enactment of the Constitution, no such law to authorize abortion has been enacted. When critically interpreted, this Constitutional clause envisages a law to be made by Parliament, the legislative body, to provide circumstances under which termination of pregnancy could lawfully be conducted. This lack of clarity has made everybody fall
back and rely on the old colonial Penal Code Act. This Act criminalizes the abortion provider, the woman herself, and anyone who knowingly supplies anything for termination of pregnancy. On a finding of guilt, it prescribes maximum prison sentences of 14, 7 and 3 years respectively. These sections of the Penal Code use the phrases “knowingly”, “unlawfully administers” and “unlawfully supplies to or procures for” in the description of abortion offences, making it appear that there is also unknowing and lawful abortion. There is very little attempt in the legislation to define when it is lawful for one to knowingly terminate a pregnancy. However, section 224 of the Penal Code provides that “A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation...upon an unborn child for the preservation of the mother’s life...” This section therefore describes a circumstance of lawful termination of pregnancy, conducted in good faith for the preservation of the mother’s life at the time of the act [4] (pp. 3-5). The section does not consider that life is a set of systems and that the threat to the woman’s life may not be immediate at the time of presentation, such as of ectopic pregnancy. Interpretation of this section may not be universal, as it could depend on the sitting trial judge. This uncertainty makes it very difficult for service providers and the policy team to explain and clarify the scope of their legal power to any intended client. The lack of clarity leaves the service provider in doubt and thus effectively denies the potential beneficiary of the section any chance to obtain legal care.

The facts above, on the form of the legal provisions, raise a duty on the government to clarify the circumstances of lawful abortion. Continued silence means that more women and girls will resort to unsafe procedures to end pregnancies that are unplanned and oftentimes unwanted. An unclear or restrictive law does not deter women and girls from terminating unwanted pregnancy, but makes terminations clandestine, leading to morbidity, miseries and/or loss of women’s and girls’ lives.

The Constitution can be utilized by the government through Parliament to clarify the circumstances within which a health worker is empowered and even duty bound to terminate a pregnancy. Lawyers could also use this lack of clarity to seek direction from the courts, to have judges pronounce guidance for clinicians in dealing with clients who are endangered by continuation of their pregnancies. Any unwanted pregnancy is potentially a dangerous pregnancy, and when we identify the danger we do not have to wait for it to become imminent due to non-clarity of the laws. The Ministry of Health (MoH) can also seek legal clarification from the Attorney General or Solicitor General so that an informative law is put in place. Once there is clarity, the MoH can then issue policies, service standards and guidelines for health workers to act as the law allows.

The 1995 Constitution also recognizes numerous rights and services that may be provided to women related to their individual conduct and biology. It mandates government to provide basic and preventive health care. Medically indicated abortion care can therefore be legitimized as preventive care, especially since evidence has shown that safe abortion, in place of unsafe abortion, will prevent the ill health and death to which pregnant women are particularly susceptible [7]. The Constitution under Article 7 also clearly indicates that Uganda shall not adopt a state religion, which signifies the secular nature of Uganda. Processes of legal definition are an option, but considering the stigma associated with abortion, they may take a long time to yield clarity to acceptance of lawful abortion. During this period, unsafe abortions will continue to be undertaken and women and girls will continue to die, or suffer severe morbidities and be shamed. The need compels reaching a more immediate solution.

3. The prevailing policy environment on abortion
In 2006, the Ministry of Health developed National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights, which allow safe abortion services for severely ill pregnant women whose life is threatened. Conditions of eligibility for lawful abortion include severe heart disease, renal disease, severe pre-eclampsia/eclampsia, severe fetal abnormalities that preclude survival in extra-uterine life, HIV-positive status, and pregnancy by rape, incest or defilement. These guidelines were updated in 2012 to include general rules and regulations for reproductive health services. They provide guidance on services for priority groups and the basic information, education and communication services that they require. [4] (p.6).

Considering that this policy was not exhaustive, the MoH, in collaboration with a Coalition to Stop Maternal Mortality due to Unsafe Abortion (CSMMUA), took to developing “Standards and Guidelines on Reducing Maternal Morbidity and Mortality from Unsafe Abortion in Uganda”, that were launched in 2015. These are more comprehensive as they provide for preservation of women’s life and health while maintaining the circumstances for which abortion is acceptable as specified in the 2006 policy guidelines[4] (p.7). Unfortunately, these were stayed due to disagreement on content by some stakeholders [2]. Currently, the 2006 guidelines are outdated, the 2012 guidelines are shelved and the 2015 guidelines are stayed. Accordingly, any policy on abortion may not be enforceable in the prevailing legal environment.

4. Values on abortion

Values are a set of overarching beliefs about right conduct that we hold deeply and are dear to us. They are often shaped by our culture and upbringing, including who we grew up with and the religious beliefs we hold dear. We are unwilling to let go of them, and consequently they have a big influence on what we do and do not do, with whom we choose to associate, and how we perform our work. They often influence the decisions we make [5]. Proponents of safe abortion often face much resistance, and women who undergo abortion become socially ostracized. The restrictive legal environment deepens the stigma and discrimination surrounding abortion. The topic of induced abortion is sensitive, and generates divergent views in a country with gender inequality and unequal power relations. The values that surround the subject are framed by several main discourses. First is the religious discourse, which is most prominent and sanctifies the life of the unborn. Following is the human rights discourse, which has two facets – the right of the child and the woman’s right to health. This discourse is further subdivided into medical and legal sub-discourses. The value judgements within the latter usually describe whether crimes are committed and if so, by whom (women and/or health care workers) and whether a woman who is forced to seek an unsafe abortion due to the strict law is its victim [6].

Due to unclarified values, young women have been turned away from contraceptive services because the provider thinks that they are too young to access them. Even when we know that sexual debut is often at 15 years of age, we feel quite uncomfortable providing an unmarried 18 year old with an effective contraceptive method. We have been brought up to believe that it is a sin to have sex at a young age, so that such a client would be turned away from an effective service. Clinics such as those in education institutions do not provide contraceptive services because they believe the students are interested only in study. Sexually-active students have no option than to turn to nearby low quality facilities for contraceptive methods, and are liable to have unplanned pregnancies. For instance, 18 year old Mirembe Sylvia is one such case (pseudo names). She sought help from an elderly woman to terminate a pregnancy after her boyfriend abandoned her. The woman took her to the bush and
administered a local herb that triggered the abortion, amidst uncontrolled bleeding. Sylvia later sought post-abortion care, but she was shamed by her family and kept out of school for a year. [4] (p.15)

The negative values on abortion continue to influence legal and policy making in Uganda. Staying the Ministry of Health Guidelines under the pretext of contest from religious groups is a classic example of how negative values continue to influence Uganda’s legal and policy environment.

5. The Harm Reduction model (HRM): Laws, policies and ethics for implementation

If a woman decides to have an abortion, she will often go ahead and seek it regardless of the legal consequences [4] (p.29). Criminalization of abortion therefore may in many cases not deter women from accessing abortions. Instead, it drives women to seek the service from unskilled providers, who frequently operate in unhygienic and uncouth environments [7], as illustrated in some voices above. In countries that have restrictive abortion laws, women can be provided with information on safer methods of clandestine abortion so that they can make a choice that reduces risk to their lives [7].

The HRM is an evidence-based public health and human rights framework that prioritizes strategies to reduce harm and preserve health in situations where policies and practices prohibit and stigmatize common human activities and drive them underground. This model was originally developed to curtail the spread of HIV/AIDS through exchange of used syringes for new ones in a community in which there was a high prevalence of sharing used syringes. It was reconceptualized in Uruguay to prevent unsafe abortion - also referred to as the Uruguay Model. [7, 10]

In Uruguay, the law provided very few legal options for abortion and even then, access to services was deterred by lengthy and tedious bureaucratic processes. This was compounded by stigmatizing of applicants by health workers who lacked the will to provide services. The result was that women would seek abortion services from unskilled providers in unsafe environments, hence risking their health and lives. In an effort to address the immediate need for safe abortion, a group of public health specialists in Uruguay designed a model of care (Iniciativas Sanitarias) to protect the health of women by reducing the risks and harm associated with unsafe abortion [7]. A recent study from the country [10] shows that maternal mortality due to unsafe abortion fell by 40% in the last ten years. The country witnessed a rapid decrease in abortion-related deaths from 37.3% between 2001 to 2005 to 7.8% by 2010 and 8.1% in 2015. The decrease coincided with the introduction of the harm reduction model within the restricted legal environment, and eventually led to decriminalization of abortion. The scenario that led to the design of the model is similar to the situation in Uganda. Maternal mortality is unacceptably high, as are the numbers of unsafe abortions and related deaths; safe abortion is usually regarded as illegal; and stigma and discrimination related to abortion are also high among politicians, communities and health workers. The model provides an opportunity to address the barriers to safer abortion now, while advancing women's reproductive health rights in the prevailing legal environment.

The model leverages the right to information, and focuses on making information available to women who have decided to terminate a pregnancy, to enable them to be safer in whatever action and collaboration they undertake. The strategy provides an opportunity for a woman or girl to get into contact with the health care system where she can discuss her concerns, and intention for her pregnancy. She can also receive pregnancy diagnosis and dating, as well as counseling for the available legal alternatives to unwanted pregnancies. Information is also given on the dangers of the available unsafe methods, for those who might resort to them.
The HRM has three principles:

a) A humanistic principle, which observes a woman's right to make a choice concerning her health, regardless of how abortion may deviate from moral or legal norms;

b) A pragmatic principle, which compels health care providers to mitigate as much harm from unsafe abortion as possible by providing women with information about the safest and most effective services and methods that are available. Women with unwanted pregnancies are encouraged to attend before and after consultations. Under the HRM, abortion as a procedure has a "before" and an "after". During these two periods, provision of information by health workers is appropriate and legal [7]. The purpose of the first (before) consultation is not to influence the woman to take a specific decision regarding her pregnancy, but to provide all the medical, legal, scientific and public information available to the woman in a non-directive manner, so that she can make a fully informed and autonomous decision about her health and life. In the event that she decides to terminate the pregnancy, she does it in a safer manner; and

c) A neutrality principle, which requires health service providers not to judge the legality or morality of abortion but to concern themselves with reducing mortality and morbidity due to unsafe abortion [7,8].

Medical abortion using misoprostol is one safe method commonly used for abortion today worldwide. This medication was originally used for prevention and treatment of gastric ulcers, but it was discovered incidentally to cause uterine contractions and cervical ripening, which is desirable for termination of pregnancy. Due to its latter use, it is currently on the WHO essential list of drugs for post-partum hemorrhage and incomplete abortion. If properly administered, it can be used to avert severity of complications due to abortion, and lower related maternal mortality rates [7].

In Uganda, misoprostol was introduced in 2008 to treat post-partum hemorrhage (PPH). It was promoted by five Civil Society Organizations (CSOs), which supported registration of the drug with the National Drug Authority, the development of clinical guidelines and the initial piloting and training of clinical workers. The CSOs and the national medical stores purchased and circulated the drug in different health facilities, two years before it was added to clinical guidelines and the Essential Medicines List. Currently, some CSOs continue to promote the use of misoprostol for off-label indications such as induction of labor and abortion, especially in the private sector [9]. There is no documented evidence on operation of the HRM or use of misoprostol for induction of labor, but the model now presents an opportunity to prevent unsafe abortions and related deaths within the confines of the law.

6. Applying Ugandan laws to the harm reduction model

The HRM can also be widely read into Uganda’s constitutional framework. The National Objectives and Directive Principles of State Policy, for instance, require the state to endeavor to fulfill the fundamental rights of all Ugandans to social justice and economic development and, in particular, to ensure that all Ugandans enjoy rights and opportunities and access to education and health services. The importance of these objectives and principles is reiterated in Article 8A(1) of the Constitution, which requires that “Uganda shall be governed based on principles of national interest and common good enshrined in the national objectives and directive principles of state policy”. In the context of health care, the state is obliged to take all practical measures to ensure the provision of basic medical services to the population. Article 33 of the Constitution, on the Rights of Women, further requires, in subsection (3),
that “The State shall protect women and their rights, taking into account their unique status and natural maternal functions in society”. Therefore, rolling out the HRM to protect against the harms of maternal morbidity and mortality could be interpreted as part of this wider constitutional mandate. As earlier indicated, under Article 7 of the Constitution, Uganda has no State religion, so religious beliefs cannot be raised as a barrier to provision of comprehensive health care.

7. **Using Ministerial guidelines to support harm reduction**

It is a duty of the Ministry of Health through policies and guidelines to inform and assist health workers to provide a wide range of quality services to all, more so reproductive health services, so that the population is able to enjoy the fullest health. The policies should contain nonjudgmental, non-moralized, correct information regarding the prevention of unintended pregnancies, safe pregnancy care, avoiding unsafe abortion including circumstances where women could access safe abortions, and access to labor management including emergency obstetric and post-abortion care. This is to ensure that people achieve their desired family size and health potential so as to contribute meaningfully to national development. The Ministry has heeded its mandate, although other stakeholders are divergent on abortion-related content of guidelines.

While the policies, standards and guidelines on abortion are currently blurred, they still have provisions that support harm reduction. The government through the Ministry of Health acknowledges the importance of access to safe termination of pregnancy. Particularly, the 2001 National Training Curriculum for Health Workers on Adolescent Health and Development [12] compels service providers to offer referral for abortion to victims of rape, while the 2007 guidelines on Management of Sexual and Gender Based Violence (GBV) Survivors [12] also provide for access to termination of pregnancy specifically in cases of sexual violence. The 2006 National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights further provide access to abortion services under specified circumstances, as elaborated above [12]. The 2006 National Policy Guidelines were updated in 2012. The latter still provide for abortion within the same circumstances as stipulated in the 2006 version. They provide for medical abortion to be provided by different cadres of health workers and surgical induction to be conducted from Health Center IV through referral to hospital level [4] (p.7).

Harm reduction requires that such information is made available to a client who interfaces with the health system. The 2015 guidelines are even more comprehensive and during their launch, the then director of community and clinical health services and current acting Director General of the MoH recognized safe abortion as a fundamental human right. The new guidelines would provide a comprehensive solution which includes primary, secondary and tertiary levels of prevention of unsafe abortion. They are intended to systematically address unsafe abortion by improving services for reducing unwanted pregnancies and expanding access to safe, legal abortion care, including post-abortion family planning services [13]. Currently, the 2007 guideline on management of GBV can be used to refer victims of GBV for abortion services.

8. **Medical Ethical guidelines to support harm reduction**

Ethics is concerned with moral principles, values and standards of conduct. The modern expression of health-related ethics in bioethics is not a preserve of any single discipline, but is multi-disciplinary and inter-disciplinary with contributions from various fields including philosophy, religious studies, medicine and law. In medical practice, the duty to act ethically lies at the very origins of the profession, dating from the Hippocratic Oath.
In clinical settings, it is expected that health professionals are professionally sound with all required competencies. It is also an expectation that while they are practicing medicine and are dealing with patients, attendants, and relatives of patients, they practice ethical behavior with relevant competencies. They have to be guided by principles such as patient autonomy, confidentiality, informed consent, human rights, equity and justice. [15]

These same principles must be extended to provision of comprehensive care including safe abortion services. The principles of harm reduction are reflected in the principles of medical ethics. Harm reduction is value neutral, and entitles women to make their choices and be respected and treated with dignity.

In Uganda, the Health Service Commission Act provides a code of conduct and ethics for health workers, prescribing the duties and responsibilities of health workers in relation to provision of health services. The Act requires health workers as a matter of priority to protect the safety, health and interest of patients (Section 30), protect the interests, observe the law and protect the dignity and honor of workers’ professions (Section 33) and to recognize and respect colleagues’ expertise so as to provide the best holistic health care (Section 34). According to the code of medical and dental practitioners in Uganda, an ethical obligation of a medical worker is to respect human rights contained both in the Constitution and in international human rights law [11]. Similar principles are prescribed under the codes of conduct for other health professionals such as nurses and midwives, including allied health professionals [15].

Ethical principles further prescribe that health workers should exercise their judgment to provide health care following agreed and carefully monitored values. They should not provide harmful care to their clients. They should undertake continuous professional scientific knowledge and advances that protect their clients. Much evidence that concerns women’s care continues to be available and health care providers are obligated to use it. Evidence shows that service provision in a non-judgmental environment that observes and maintains the known international human rights of clients improves client satisfaction and access to safe and quality reproductive health care. If this goal is supported, it provides a key for the HRM in wholesome care to women with unwanted pregnancies. One example is 15 year old Nabukeera who was raped while unconscious. Her mother supported her to seek medical advice. The doctor counseled her on available options. She decided on having an abortion, secured it safely, and shortly returned to school [4] (p9). She is one of many who could have taken a different decision that would complicate her health if the model was not an option.

In a narrative from a medical consultant at a regional referral hospital, doctors take an oath to protect the confidentiality of their clients. Under this oath, they are supposed not to report abortions and they are obligated to remove any identifiers when discussing clients. However, he notes that police and state prosecutors threaten health workers, who may succumb and disclose the information [4] (p.21), observing that “I know about five doctors who have been arrested and some of them I have read in the papers. The police don’t differentiate between abortion and post-abortion care, so they arrest them as the same—and yet post-abortion care is not criminalized”. For a harm reduction strategy to work, it needs to be clear to the health care provider, the women concerned and the police that post-abortion care is not abortion. While it is important to educate different sections of the population on what the law permits, it would also be helpful to work with sympathetic prosecutors to develop prosecutorial guidelines on matters relating to abortion so as to hold police accountable for compelling breaches of ethical duties of confidentiality.
9. Conclusion

Unsafe abortion continues to occur in Uganda in the face of restrictive laws, high maternal mortality and negative value judgments. This paper shows that despite the laws on abortion being unclear and that health ministry guidelines are stayed, there are still ways that laws, policies and ethical guidance can be used to institute a harm reduction model in Uganda to the advantage of women’s survival and health. The illumination of principles such as human rights and medical ethics in Uganda’s laws and policies provides the bedrock for advancing the harm reduction model. This model has shown evidence of benefit to avert related complications in environments like Uganda, while raising the dignity and rights of women with unwanted pregnancies. However, considering that the model in Uganda is undocumented and generally unknown, it is important to sensitize the Ugandan population about what it is, and its benefits. It is even more important to clarify values and ethical responsibilities of health workers who serve women for a harm reduction model to succeed.

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