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UGANDA COUNTRY REPORT

NEEDS ASSESSMENT ON SAFE ABORTION ADVOCACY

FOR THE UGANDA OBSTETRICAL AND GYNAECOLOGICAL SOCIETY (AOGU)

COMMISSIONED BY THE INTERNATIONAL FEDERATION OF GYNAECOLOGY AND OBSTETRICS (FIGO)

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Executive Summary

This report describes the needs assessment set out to provide better and more in depth understanding of the capacity of the Association of Obstetricians and Gynaecologists of Uganda (AOGU) and in particular to identify the main abortion advocacy needs that a forthcoming multi country project can address. The assessment attempted to provide more clarity on how FIGO can effectively strengthen the capacities of the society. The assessment involved conducting a literature review, a survey of members of the society and key informant interviews with stakeholders at various levels as well as a stakeholder workshop for AOGU members and partners. The majority of key informants were associated with AOGU.

The literature review, the key informant interviews and the workshop confirmed that unsafe abortion and its complications is a major problem in Uganda, endangering the lives of many women. The restricted abortion law, the absence of a supportive policy environment as well as cultural and religious believes, make it extremely challenging to provide safe abortion services or even openly discuss the issue. Building its base as a safe abortion advocate, AOGU will require to address the various and potential challenges as they were identified during the key informant interviews and the two day's workshop. This could include the following:

- Strengthening the management and organization of AOGU in their capacity of safe abortion advocates
- Establishing a coordinated and vibrant network of associations that are supportive of safe abortion
- Transforming the social and gender norms at all levels regarding safe abortion but within the context of the Ugandan law
- Ensuring that the policy environment is conducive and provides a framework for health workers to provide safe abortion care without fearing legal implications
- Ensuring a process for data generation and use for monitoring and planning for services

These recommendations, identified in collaboration with AOGU, are taken forward and translated into a preliminary action plan with tangible activities and outcomes. The action plan will be further developed in collaboration with AOGU and FIGO and be a source of inspiration for the development of a future program proposal for safe abortion advocacy in 10 countries (Kenya, Benin, Cameroon, Ivory Coast, Mali, Mozambique, Panama, Peru, Uganda, Zambia).

1. Introduction

This country report is the result of a needs assessment conducted by KIT Royal Tropical Institute with the Association of Obstetricians and Gynaecologists of Uganda (AOGU) regarding Safe Abortion Advocacy. Uganda is one of the ten countries participating in a broader Needs Assessment for an upcoming multi-country FIGO-led project that aims to increase the capacity of national obstetrics and gynaecology societies to become national leaders in safe abortion advocacy work.

1.1 Needs Assessment Purpose

This Needs Assessment is the first phase of an upcoming safe abortion project and it should provide a better and more in depth understanding of the capacities and needs of AOGU. Subsequently, it will identify the main needs in relation to safe abortion advocacy that the following multi country project could address. Also, it should provide more clarity on how FIGO can strengthen more effectively the capacities of national societies, in this case AOGU. This includes the provision of recommendations on the content of the capacity building program by developing country action plans with budget, as well as a comprehensive program proposal for the whole ten countries.

1.2 Needs Assessment Objectives

The specific objectives are that by the end of the needs assessment in ten countries, FIGO should have:

- Insights on the situation of abortion in each country
- Understanding of the capacity and needs of each National Obstetrics and Gynaecology Society on advocacy for safe abortion
- Plans of Action for each National Obstetrics and Gynaecology Society developed through a collaborative process
- Recommendations on FIGOs role to strengthen the capacity of the ten National Societies as safe abortion advocates, translated into a comprehensive proposal

2. Methodology

This Needs Assessment was formative of character and aimed for a highly participatory approach. Constant mechanisms of communication and feedback with AOGU took place in order to create mutual understanding and joint objectives.

The following methods were used in order to meet the objectives of the assessment:

1. Desk study review

A desk study review on existing literature and evidence was committed between March and April 2018 through a desk review tool. Academic databases and grey literature were searched for the relevant themes as addressed in the assessment framework (inception report). AOGU and key stakeholders were requested for relevant input.

2. Online survey

An online survey, using Survey Monkey software, was sent out to all 229 registered members of AOGU to ask them about their membership of AOGU, the position of the society towards safe abortion and their own professional and personal position towards safe abortion. While the preference was discussed to send out email invitations directly from the software¹, this appeared logistically not feasible. AOGU sent out the web link to their members on 16 March 2018. Despite several reminders to attain more responses, only 22 responses came back (<10% response rate), 21 of them were complete (completion rate 95%; one respondent did not continue after question 21). The survey remained open for 6 weeks and closed on 29 April 2018. Analysis was done using the survey monkey software. All answers that were provided on all questions were included in the analysis.

3. Key Informant Interviews

A total of 14 key informants were interviewed during the last week of March and first week of April 2018. They included representatives from AOGU, Family Life Network, Centre for Human Rights and Development (CEHURD), Ministry of Health (MOH), Ipas, College of Health Sciences, Family Health Department Population Secretariat, Ministry of Gender, Makerere university, a member of parliament and an Anglican reverent. The interviews were conducted either within their offices, home or at an agreed location of convenience. With permission, the interviews were recorded as well as taking of notes. These notes were extended using the tape recordings. The notes were collated and organized along thematic areas as outlined in the findings section. The findings were analysed taking into account the various perceptions regarding safe abortion.

4. Stakeholder workshop

A two days stakeholder workshop took place in Kampala on 28th and 29th March. The purpose of the workshop was to identify the needs of AOGU for abortion advocacy and develop a plan of action for

¹ During the inception phase it was agreed with FIGO that, in order for the survey to be submitted only once per member and to avoid the survey being forwarded to others who could then influence the outcome into a more positive or negative way, an invitation to the survey should preferably be sent out directly from the software to a list of email addresses; these invitations can be used only once. In case of this being not feasible, a password-secured web link to the survey would be sent out by the society with the password in a separate email.

the next safe abortion advocacy proposal that will be developed for the National Societies of Obstetrics and Gynaecology in ten countries involved in the needs assessment.

The objectives were that by the end of the workshops participants have:

- Discussed and identified opportunities and barriers for providing safe abortion in the country based on the desk review presentation and own experience.
- Explored their personal and professional values related to abortion and identified activities for improving access to safe abortion and post abortion care based on professional ethics.
- Explored the implications of the national abortion law and policies for access to safe abortion.
- The ability to explain the concept and levels of advocacy and identify challenges and barriers of abortion advocacy.
- Identified the strengths and weaknesses of the national society in abortion advocacy.
- Formulated action points for an abortion advocacy programme.

A total of 18 participants attended, most being present for either days, some attending only the first or second day. A full program of the workshop and list of participants can be found in Annex 1.

3. Challenges and Limitations

One of the main challenges perceived was to get responses to the survey. The team, in collaboration with AOGU, took several actions to mitigate the limitation of a low response rate. AOGU members that participated in the workshop and had not filled out the survey prior to attendance were requested to fill in the survey immediately upon arrival on a printed copy that was made available by AOGU. 6 participants completed a printed copy, which were entered in survey monkey by the KIT consultant. The survey was also promoted by AOGU through sending several reminders. While it was emphasized that AOGU is interested to hear the voices of all members, regardless of their position, it is expected that mainly those who have strong feelings about the topic took the effort to respond. With a total response rate of only 11.7% this survey cannot be seen as a reliable representation of the complete variety of AOGU members. The majority of the people who took the effort to fill in the survey were generally supportive of safe abortion to save a woman's life, whilst there were only a few respondents who supported abortion on request of the woman.

There were also challenges experienced in organizing the Key Informant Interviews in the short time allocated for this. We finally did manage to get interviews with 14 key informants, however, some interviews were cancelled because the interviewees were not available at the planned days, or because the interviewee did not feel comfortable answering on behalf of the organization or institution they worked for. We did have a good variety of respondents, and we felt that we reached a saturation point. However adding some more interviews could have shed more light on various perspectives of the issue of safe abortion and the need for advocacy in Uganda.

In terms of the workshop the attendance was largely by those from the medical field. Participants would have appreciated that representatives of the legal field attended the workshop to bring in legal aspects of safe abortion and advocacy perspectives. While AOGU invited legal professionals and active advocates from the legal side to the workshop, they did not attend for unknown reason.

4. Findings

4.1 Literature review

4.1.1 Demographic and socio economic information

According to the 2014 Population and Housing Census, Uganda had a population of 34.6 million people with high Total Fertility Rates (TFR) of 5.4 children per woman (UBOS & ICF, 2016) implying a high population growth rate of 3.0%. The country has a youthful population with 47.9% between 0-14 years, 49.2% between 15 – 64 years and 2.9% above 65 years. In addition to that, the dependency ratio is 103 which implies that for every 100 economically active persons there are 103 dependents (Republic of Uganda, 2017). Majority of the population (75%) reside in rural areas while only 25% of the population resides in urban areas (UBOS, 2014). The high population growth has made demographers at National Population Council project Uganda's population to be 47 million by 2025 and 63 million people by 2030 (Ggoobi, 2016).

High population growth rates often compete with the growth rate of household incomes. In Uganda, the former is currently winning the race. Increase in population cancels out the increase in aggregate output which keeps average incomes low and stagnant thus keeping people in the vicious cycle of poverty (Ggoobi, 2016). Uganda's youthful population is majorly unskilled or semi - skilled and as well not financially empowered. Going by the official GDP series, Uganda's economy has grown, quite impressively. However, people tend to look at their situation and wonder whether indeed the economy has grown as fast as is indicated in the official figures from Government. Recently, the economy narrowly evaded a full-blown recession, but GDP has experienced four quarters of negative growth in the last five years (World Bank, 2017).

4.1.2 Sexual and Reproductive Health Rights (SRHR) indicators and abortion evidence

Uganda's reproductive health indicators are poor. For instance, the maternal mortality ratio is estimated to be 310 - 438/100,000 live births, or almost 5000 women dying annually of pregnancy-related causes. While maternal mortality has declined in Uganda in the last decade, levels remain very high and Ugandan women suffer severe morbidity (CEHURD, 2016; Amnesty international, 2010; Larsson et al, 2015; Nalwadda et al, 2017).

In Uganda contraceptive use remains very low, only 17% of all women of reproductive age, and 18% of married women, utilize modern contraception. In addition to limited access because of sporadic stocks of contraceptives, many providers do not have sufficient knowledge about long-acting methods, emergency contraceptives and barrier methods apart from condoms (Mulumba et al 2017). Unintended pregnancy is common in Uganda, leading to high levels of unplanned births. Adolescents and young adults are particularly at risk for unintended pregnancy. Close to half of the 1.4 million annual pregnancies occurring in Uganda are unwanted (Nalwadda et al, 2017; Mulumba et al, 2017).

Unintended pregnancies have been strongly linked to unsafe abortions, constituting nearly one third of maternal deaths among the country's young people (Republic of Uganda, 2017). A national estimate of abortion incidence in Uganda reported an annual abortion rate of 53 abortions in every 1000 women, which is much higher than the average rate for Eastern Africa (36 abortions per 1000 women). It has been estimated that about 297,000 illegal abortions are performed yearly in Uganda. A large

proportion is conducted under unsafe conditions by people without medical training, resulting in nearly 85,000 women treated annually for abortion related complications. The average cost to the Ugandan healthcare system of treating complications from unsafe abortion was nearly US\$130 per patient in 2009 and post abortion care is estimated to cost nearly \$14 million annually. Most costs of post abortion care arise from treating incomplete abortions and a substantial proportion is spent treating more serious complications, such as sepsis and perforations (Mulumba et al 2017). 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 (Mulumba et al, 2017).

4.1.3 Legal and political context

National laws and policies on abortion

Under the Ugandan Penal Code of 15 June 1950 (sections 136-138, 205 and 217) the performance of abortions is generally prohibited (Republic of Uganda, 1950). Nonetheless, under other provisions of the Penal Code an abortion may be performed to save the life of a pregnant woman. The Penal Code Act (Cap. 120), as amended through the Penal Code (Amendment) Act, 2007 (Act No. 8 of 2007), Sections 224 provides that a person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his or her benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time, and to all the circumstances of the case. In addition, Section 205 of the Code provides that no person shall be guilty of the offence of causing by wilful act a child to die before it has an independent existence from its mother if the act was carried out in good faith for the purpose of preserving the mother's life (Republic of Uganda, 1950).

Moreover, Uganda, like a number of Commonwealth countries, whose legal systems are based on the English common law, follows the holding of the 1938 English *Rex v. Bourne* decision in determining whether an abortion performed for health reasons is lawful. In the *Bourne* decision, a physician was acquitted of the offence of performing an abortion in the case of a woman who had been raped. The court ruled that the abortion was lawful because it had been performed to prevent the woman from becoming "a physical and mental wreck", thus setting a precedent for future abortion cases performed on the grounds of preserving the pregnant woman's physical and mental health. The liberalization and legality of abortion in Uganda has been complicated by the use of rape as a weapon of war and terror by rebel groups in the region.

The Constitution of the Republic of Uganda (1995), Article 22(2) provides that no person has the right to terminate the life of an unborn child except as may be authorized by law. This means much as abortions are illegal in Uganda, there are situations where they could be considered legal. The Penal Code Act (Cap. 120), as amended through the Penal Code (Amendment) Act, 2007 (Act No. 8 of 2007), Sections 141-143, 212 and 224 makes various provisions (Rep. of Uganda, 1995)

The 2006 National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights were permitting abortion in cases of foetal anomaly, rape, incest or defilement, severe heart disease, renal disease, severe pre-eclampsia/eclampsia, or a woman's HIV-positive status, (Ministry of Health, 2006), however these policy guidelines have been retracted by the Minister of Health on the same day they were supposed to be launched and these conditions are no longer covered under the legal framework.

The National Adolescent Health Policy for Uganda is in place and the overall goal of this policy is to mainstream adolescent health concerns in the national development process in order to improve the quality of life and standard of living of young people in Uganda, however, the policy is silent on issues of abortion (Rep. of Uganda, 2004).

Implementation of legal abortion

According to the law, a doctor who thinks that there is need to perform an abortion in order to save the life of the mother must write to the Director General of Medical Services at the Ministry of Health seeking permission to terminate the pregnancy. When the Director General of Medical receives the letter, he/ she then forms a board usually made up of Medical experts who will then discuss the case at hand, and where possible, appoint a doctor to carry out the abortion (Ministry of Health, 2006). Of course the question then arises, if it's an emergency situation and a quick decision is needed to save the mother's life, how then should someone have time to start writing letters, and for the board to meet and consider the situation at hand.

It must be emphasized that it criminalized the one who aborts and the one who aids abortion (Republic of Uganda, 2007). In 2016 From January to May, the police recorded 325 cases related to abortion, yet last year 1800 cases were recorded. In 2014, 1600 cases were recorded. Despite laws criminalizing abortion, it remains a grim reality with most of the scenarios arising from bitter relationships. These are just a few cases that are reported. Women who have requested abortion and/or their relatives only go to police when there is a death or major injury involved. Even those that go to police, after investigations only a few cases proceed to court (Nassaka, 2016).

Role of legal institutes

Despite the existence of many law institutes like Legal Aid Project (LAP), Law Council, and Uganda Law Society (ULS), they have not been active on issues of abortion advocacy. Makerere University lawyers, together with a number of Civil Society Organizations have taken government to the constitutional court for failure to formulate laws that legalize abortions (Atungisa, 2017). The legal status of abortion in Uganda is unclear because it provides for some exceptions while criminalizing the procedure in most cases. Two lawyers,

Legal implications of illegal 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

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

Any person who unlawfully supplies to or procures for any person anything, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman, whether she is or is not with child, commits a felony and is liable to imprisonment for three years

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

The Penal Code Act (Cap. 120), as amended through the Penal Code (Amendment) Act, 2007 (Act No. 8 of 2007), Sections 141-143, 212 and 224 (Republic of Uganda, 2007)

Prof. Ben Twinomugisha and Dr. Rose Nakayi, supported by the Center for Human Rights and Development (CEHURD) requested a court order, directing the executive and parliament to immediately pass a law regulating termination of pregnancies (Atungisa, 2017). In their application, the lawyers argue that the existing laws do not take into consideration young girls who get unintended pregnancies and are probably not ready to start parenting (Atungisa, 2017).

4.1.4 Abortion stigma

Little research has been conducted in relation to societal views on abortion within the Ugandan society. However, 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 (retracted in 2017). A religious discourse and a human rights discourse, together with medical and legal sub discourses frame the subject of abortion in Uganda, with consequences for who is portrayed as a victim and who is to blame for abortions taking place. The Catholic Church has a strong position within the Ugandan society and their stance on abortion tends to have great influence on the way other actors and their activities are presented within the media, as well as how stakeholders choose to convey their message, or choose not to publicly debate the issue in question at all (CEHURD, 2016).

The attitude toward services that can help prevent unintended pregnancy and unsafe abortion are worrisome in Uganda. 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. Healthcare providers indicated that even when they know that sexual debut is often at 15 years of age, they feel quite uncomfortable providing an unmarried 18-year-old with an effective contraceptive method. They noted that they 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 (CEHURD, 2016). 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 (CEHURD, 2016; Amnesty international, 2010; Larsson et al, 2015; Nalwadda et al, 2017).

Stigma and discrimination experienced by pregnant adolescents impact on their rights to health and education. Pregnant young women – particularly those who are unmarried – are subject to violence by family members and may be sent away from their homes, are expelled from school, and receive “rude, abusive and threatening treatment” from healthcare workers when they attempt to seek pregnancy-related care. This stigma and discrimination push some young women to procure unsafe abortions, risking their health and lives (Slattery and Nassali, 2011).

Additionally, although Uganda recently ratified the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (Maputo Protocol), which supplements the African Charter and provides broad protections for women’s human rights, the government reserved on Article 14(1)(a), which guarantees women the right to control their fertility (Africa Union, 2003). The government further reserved on Article 14(2)(c), which would have expanded access to safe abortion services to include exceptions to preserve the woman’s health and in cases of rape and incest.

4.1.5 Gender

In Uganda, 68% of ever-married women experienced some form of violence by their husband or intimate partner. Cultural and societal views perpetuate violence against women, with 70% of women believing that physical violence against women is justifiable in at least certain circumstances. Despite these high rates of sexual violence, the Sexual Offences Bill remains pending in Uganda's Parliament (Amnesty International, 2010). In 2009, the African Commission on Human and Peoples' Rights (African Commission) expressed concern about the prevalence of domestic violence. In 2002 and again in 2010, the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) Committee expressed concern about the high incidence of sexual violence against women in Uganda, calling on Uganda to address the persistent patriarchal patterns of behaviour and the existence of stereotypes relating to the role of women, which perpetuate violence and discrimination against women (Nassali, 2011).

Over one-quarter of young women have begun childbearing by age 17, with close to 60% of women having given birth to one or more children by age. Stigma and discrimination experienced by pregnant adolescents impact on their rights to health and education. Pregnant young women – particularly those who are unmarried – are subject to violence by family members and may be sent away from their homes, are expelled from school, and receive “rude, abusive and threatening treatment” from healthcare workers when they attempt to seek pregnancy-related care. This stigma and discrimination push some young women to procure unsafe abortions, risking their health and lives (Slattery and Nassali, 2011).

4.1.6 Service Delivery Environment

General health services and infrastructure

The national health system is comprised of both private and public sectors (Nakisozi, 2014). The private health sector is comprised of Private Not for Profit (PNFP), Private Health Practitioners (PHPs), and Traditional Contemporary Medicine Practitioners (TCMPs) (Ministry of Health, 2010). These private sectors contribute to about 50% of the Health care delivery (Nakisozi, 2014). Health services delivery is decentralized within national, districts and health sub districts. The lowest level is supposedly the Village Health Teams (VHTs) that facilitates Health Promotion, service delivery, community participation, and empowerment. At the district levels, there are Health Center III and II, with Health Center II providing a first level of interaction between the formal health sector and communities (Ministry of Health, 2010; Nakisozi, 2014). The referral system is from the lowest to the highest level of care in the service delivery system (Ministry of Health, 2010; Nakisozi, 2014).

Availability of safe abortion services, methods and providers

Safe abortion care services are not routinely provided and there is no clear universal method used for safe abortion services in Uganda. Where they are done like in severe pre-eclampsia, the induction is done with medical methods misoprostol supplemented with oxytocin for gestations above 12 weeks or manual vacuum aspiration for gestations 12 weeks and below. The use of manual vacuum aspiration is not universal in Uganda for that indication (Kiggundu et al, 2008).

There are some non-governmental initiatives funded by the Safe Abortion Action Fund (SAAF), including The Community Health Rights Network (COHERINET), a network of activists aiming to increase information on the safe use of medical abortion in the country. This project hopes to empower women by increasing their knowledge about safe abortion with pills by launching a sexual health hotline and other community level strategies. The project also aims to improve the operating

environment for safe medical abortion service providers by sensitizing Ministry of Health officials, law enforcement officers and human rights organisations on sexual reproductive health rights. Kyetume Community Based Health Care Programme, has been running the *Emergency Post Abortion Care Project* since 2011 and the project will end in 2018. It aims to decrease abortion-related complications by working with local community volunteers to promote safe post-abortion care services, improve voluntary uptake of post-abortion contraception and improve the quality of the services provided by local partner clinics. Lady Mermaid's Bureau is a small sex-workers' rights organisation based in Kampala. Since 2014, they have trained 7,158 sex-workers across eleven towns in information about their rights and how to avoid unsafe abortion. Volunteers for Development Association in Uganda (VODA Uganda), with their 'Strengthening Community Response against Unsafe Abortion' project empower young people as change-makers in their schools and communities (SAAF, 2018).

Post Abortion Care

Post-Abortion Care (PAC) should be provided on a 24-hour basis in all hospitals and health centres where there are doctors, midwives and clinical officers trained in comprehensive abortion care and where the minimum hygienic standards are met. These facilities should observe the patients' rights. Services to be offered under PAC include emergency care of abortion complications including resuscitation, evacuation of a uterus for incomplete abortion (including the use of a manual vacuum aspiration if gestation is 12 weeks and below); appropriate referral; post abortion counselling including self-care, post treatment expectations, post abortion family planning and services (Ministry of Health, 2006).

For Post Abortion Care (PAC), Manual Vacuum Aspiration (MVA) is used to evacuate the uterine contents for gestations 12 weeks and below while the sponge forceps/curate is used for bigger gestations. Manual vacuum aspiration is the preferred method for uterine evacuation but not all providers of post abortion care are competent in its use mainly because for some this technology was introduced in Uganda after they had left the training institutions and have not had an opportunity to undergo refresher courses in MVA. Not all the medical training schools offer MVA training for the students. The training curricula have only limited time for abortion care management and it's more of the theoretical care than the practical aspects (Kiggundu et al, 2008).

Post abortion family planning and linkages with other reproductive health services should be an integral part of post abortion care training in the institutions. There is need to provide in-service training for the health care givers to obtain the right attitude and skills in the provision of post abortion care including the use of the manual vacuum aspirator (Kiggundu et al, 2008).

Currently the providers of PAC that also provide MVA include the midwives and the medical officers. There is need to review the basic training of this cadre of providers to provide skills for PAC including MVA. There is need to expand the categories of health providers that can provide quality Post abortion care. Service delivery for PAC needs to be available as an emergency and at all times (i.e. 24 hours a day) From surveys done, women access PAC including MVA only during the day times and most often only on working days. This limits access to services. In some units Post abortion family planning services are provided separately yet we need to offer them close to the emergency treatment area to improve on access and eliminate missed opportunities (Kiggundu et al, 2008).

4.1.7 Unsafe provision

Whilst the desk review yielded little recent evidence to show who the providers of unsafe abortion are in Uganda, Prada et al found in their study that wealthier women are more likely to obtain abortion from providers considered relatively safe by them, including doctors, midwives and nurses. Poor women, and women from rural areas however have less access to health professionals and are more often turning to traditional healers, other lay practitioners and pharmacists for abortion services, which they consider less safe, or they self-induce the abortion, for example with herbs. Most non-medical providers in urban areas are thought to use hormonal drugs or rubber catheters, and many in rural areas turn to herbs and sharp objects. Unsafe procedures, including oral or intra-vaginal introduction of herbs, caustic substances, drugs, and/or sharp objects, result in complications that can be quite severe and even result in permanent damage to the body (Prada et al 2005). Nowadays the use of misoprostol has influenced the means and complications of unsafe abortion in Uganda, which will be further clarified in other parts of this report.

4.1.8 Advocacy activities and actors

Several private and public providers have championed efforts for a sustained advocacy on abortion issues. Some individual organizations like Marie Stopes, Reproductive Health Uganda and CEHURD are at the centre stage of abortion and SRHR advocacy in Uganda. Their work is corroborated by the Ministry of Health that has been developing and implementing legal and regulatory frameworks in the said field. As discussed before, involvement in reviewing the National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights (first version 2006, updated in 2015, retracted in 2017) is an important opportunity for advocacy (Ministry of Health, 2006). The recent case pursued by the Makerere University Lawyers (Atungisa, 2017), is a big opportunity to provide clarity and interpretation of the law on abortion. There is need to develop a model law on abortion at the East Africa Community level, through the East Africa Legislative Assembly. Member countries will be able to domesticate the law. The sexuality education guidelines that have been produced by the Ministry of Education provide a better avenue to undertake abortion advocacy.

4.1.9 AOGU

The Association of Obstetricians and Gynaecologists of Uganda (AOGU) is a registered non-profit, professional organization with a mandate to promote professionalism, undertake research, represent its members at local, regional, international level and champion Sexual Reproductive Health & Rights of the people in the region. AOGU was established in 1985, when a small group of obstetricians began to realize that professionals in their discipline were much separated and that it would be more beneficial to group together and work as a team. The vision of AOGU is to be a leading champion of quality reproductive health in the region. The mission is to provide good leadership at all levels, for quality reproductive health in the region. The association has 188 members with 43 associate members distributed country wide and working in various positions and areas of health care delivery. AOGU has established relationships with several partners and is involved in many projects. AOGU also moved forward by extending membership to include other disciplines, including midwives and nurses. It is a member of Uganda Medical Association, the East Central and Southern African Obstetrics and Gynaecological Societies (ECSAOGS), African Federation of Obstetrician and Gynaecologists (AFOG) and International Federation of Gynaecology and Obstetrics (FIGO). Whereas AOGU has the necessary infrastructure to undertake abortion advocacy, there is still need for capacity building in terms of service delivery, retooling personnel in advocacy, financing and other support services.

4.2 Online Survey

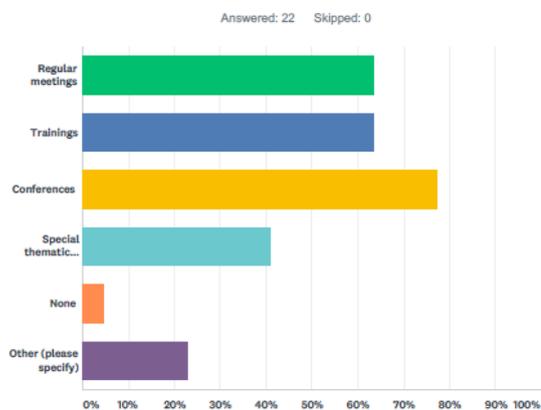
The response rate of the survey was low, with a total of 22 (11.7%) responses (21 complete), the outcomes cannot be taken as a reliable representation of the overall society, however, the results provide some valuable information about the position AOGU takes and communication to its members. An overview of the outcomes of all questions of the survey can be found in Annex 3.

4.2.1 Member characteristics of respondents

The majority had been an obstetrician/gynaecologist (11) and a member of the association (12) for 5 to 15 years. 5 respondents were a member for less than 5 years, whilst 5 respondents have been a member for 15 – 30 years. 18 respondents indicated that they were also a member of another professional body, mostly mentioned were Uganda Medical Association (UMA), Uganda Fertility Society, and East Central and Southern African College of Obstetricians and Gynecologist (ECSACOG). Others mentioned; Islamic Medical Association of Uganda (IMAU), Uganda Women Doctors Association and FIGO.

All respondents indicated to feel involved with AOGU, however the level of involvement varied, whereas 9 respondents felt very involved, 4 felt involved, 6 moderately involved and 3 only slightly involved. Half of the respondents said they attended activities often. Events and activities that were attended by most respondents included: Regular meetings (64%), Trainings (64%) and Conferences (77%).

Q6 What activities or events of the Association of Obstetricians and Gynaecologists of Uganda do you attend?



4.2.2 Communication between AOGU and its members

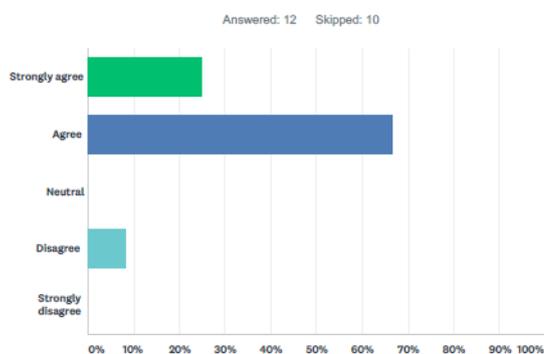
All respondents answered to receive communication of AOGU through mail updates. Calls, Social media, WhatsApp and the website were means of communication mentioned by over 50% of the respondents. The national journal and newsletter were only mentioned by a few. The frequency of communication was indicated to be weekly by nine respondents, whilst others said this was monthly (6), quarterly (3) or yearly (1). Others mentioned; “as need arises” (3).

A vast majority (73%) said communication is acceptable, but can be strengthened. It was felt by some respondents that this is due to some members working up country and communication is difficult for them and that not everybody is using WhatsApp. Suggestions included to have more regular email updates, start an association journal, newsletters and social media.

4.2.3 About AOGU’ position towards safe abortion

Most respondents answered that AOGU does have a clear position on abortion (55%), whilst 27% said that the position is not clear and 4 respondents said that they don’t know. Of the 12 respondents that know about AOGU’s position on safe abortion, 8 (67%) agree, and 3 (25%) strongly agree with this position, whilst one respondent disagrees. However the perceived position of the society varied a lot between respondents. Responses included: “safe abortion should be legalized and made available to all women” “abortion done on medical grounds” “Not yet supportive due to the laws of the land against providing abortion services. Ethical principles and Hippocratic oath held high by most members - all reserved not to advocate for abortion.”

Q14 To what extent do you agree or disagree with the position on safe abortion of the Association of Obstetricians and Gynaecologists of Uganda?



Although the views regarding the position of AOGU are diverse, 67% of respondents said that AOGU informs members about their position, through emails (50%), meetings (62%) and trainings (75%). 86% of respondents said that AOGU informs its members on new evidence on abortion, abortion laws, policies and practices (mainly through trainings, meetings and emails) and almost all (with the exception of 1 respondent) would like to receive more information. None of the respondents felt uninformed about laws, policies, guidelines, abortion practice, post abortion care policies and guidelines, only on international safe abortion guidelines 32% felt slightly informed, all other aspects were mainly scored with moderately informed, to very informed.

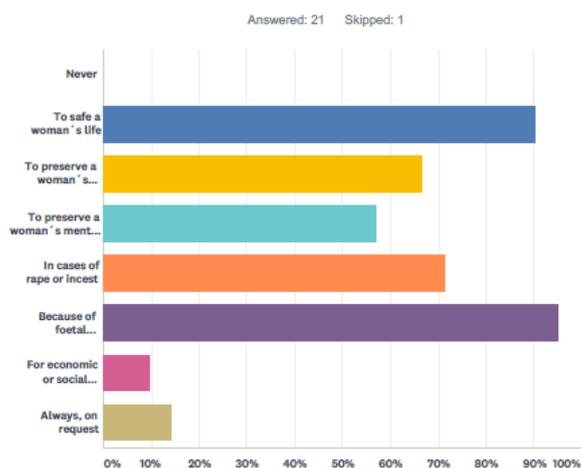
Q 21: How informed do you feel about the following themes?

	NOT INFORMED	SLIGHTLY INFORMED	MODERATELY INFORMED	INFORMED	VERY INFORMED	TOTAL	WEIGHTED AVERAGE
The national laws on abortion	0.00% 0	0.00% 0	40.91% 9	40.91% 9	18.18% 4	22	3.77
International guidelines on safe abortion	0.00% 0	31.82% 7	18.18% 4	36.36% 8	13.64% 3	22	3.32
National Policies on safe abortion	0.00% 0	4.55% 1	50.00% 11	22.73% 5	22.73% 5	22	3.64
Practical information related to the practice of safe abortion (guidelines, recommendations, procedures)	0.00% 0	4.55% 1	27.27% 6	40.91% 9	27.27% 6	22	3.91
International guidelines on post abortion care	0.00% 0	9.09% 2	18.18% 4	36.36% 8	36.36% 8	22	4.00
National Policies on post abortion care	0.00% 0	0.00% 0	27.27% 6	36.36% 8	36.36% 8	22	4.09
Practical information related to post abortion care (guidelines, recommendations)	0.00% 0	4.55% 1	22.73% 5	31.82% 7	40.91% 9	22	4.09

4.2.4 About respondents' position towards safe abortion

A majority felt that abortion should be permitted to save a woman's life (90%), to preserve a woman's physical health (67%), to preserve a woman's mental health (57%), in cases of rape or incest (71%) and/or because of fetal impairment (95%). A minority felt that abortion should be permitted for social or economic reasons (9.5%) or always, on request (14%). None of the respondents said that abortion should never be permitted.

Q22 Under which circumstances do you think safe abortion should be permitted/legal?



A majority of the respondents agreed with the following statements:

- Safe abortion is part of healthcare and should not be separated from the rest of medicine (24% agree, 38% strongly agree) (however 29% answered “neutral” and 10% disagree)
- Health workers opposing to perform safe abortion should be obliged to refer women to other health workers that will perform a safe abortion (43% agree, 33% strongly agree)
- Health workers have role to play as advocates for safe abortion (57% agree, 29% strongly agree)
- Post abortion care is part of healthcare and should not be separated from the rest of health care (14% agree, 81% strongly agree)
- Specialized health workers (Obs-Gyn) should be obliged to perform safe abortions in cases where it is permitted by law (38% agree, 23% strongly agree)
- Health workers should have the right to decide whether to perform or not safe abortions according to their personal values and positioning towards abortion (29% agree, 38% strongly agree)

All respondents agreed with:

- Health workers should be obliged to provide post-abortion care to all women, no matter if the abortion was legal or not (10% agree, 90% strongly agree)

And the majority disagreed with:

- Safe abortions should be only performed in private clinics, not in the public health system (57% strongly disagree, 33% disagree)
- Health workers should report to the respective authorities cases with signs of illegal abortion (62% strongly disagree, 24% disagree)

A vast majority of the respondents said to support AOGU in advocacy for safe abortion (48% definitely, 19% very probably, 19% possibly).

4.3 Key Informant Interviews (KII)

A total of 14 key informants were interviewed during the last week of March and first week of April 2018. They included representatives from AOGU, Family Life Network, Centre for Human Rights and Development (CEHURD), Ministry of Health (MOH), Ipas, College of Health Sciences, Family Health Department Population Secretariat, Ministry of Gender, Makerere university, a member of parliament and an Anglican reverent. (*Table 2*).

Table 1: Key Informant Interview participants

No.	Association/ Society/Organisation	No of Respondents
1	Association of Obstetricians and Gynaecologists Uganda (AOGU)	3
2	Family Life Network	1
3	Centre for Human Rights and Development (CEHURD)	1
4	Ministry of Health	1
5	Ministry of Gender	2
6	College of Humanities	1
7	Ipas	1
8	College of Health Sciences	1
9	Member of Parliament	1
10	Anglican Church - Reverent	1
11	Family Health Dep. Population Secretariat (Popsec)	1
	TOTAL	14

Data collected from the key informant interviews were analysed based on the following broad thematic areas:

- Safe abortion environment
- Professional associations' position on safe abortion
- Level of influence on policy change
- Relationship between professional societies
- Personal position on safe abortion
- Obstacles to safe abortion advocacy
- Opportunities for strengthening safe abortion network
- Current role in safe abortion advocacy.

4.3.1 Safe abortion environment

All key informants agreed that unsafe abortion is a huge problem in Uganda and highlighted the issue that safe 'legal' abortion is not available and accessible, except for rare cases, whereby abortion is the only way to save a woman's life. Even very experienced gynaecologists said that they hardly ever carried out an abortion under such legal circumstances. The law is not very clear about the definition of when the life of a mother is in danger. The policy guidelines included more conditions, like rape and incest, but these have been withdrawn. Many respondent made clear distinction between illegal abortions which they consider safe (those carried out by a skilled person, whether or not in a health facility), and unsafe (by unskilled persons, or by skilled persons, but under unhygienic circumstances).

Marie Stopes, Reproductive Health Uganda (RHU) and Pace, as well as private institutions (such as doctors at universities) were thought to be providers of SRHR services, but not openly communicating

about abortion services. Whilst safe abortion services should be available in 14 public hospitals, in reality it is available in only 1 hospital, and PAC is thought to be available only in 14 – 35% of health facilities. PAC is provided by doctors, clinical officers and midwives, although various answers were given about who is trained. MOH with PSI and Marie Stopes train district health teams on PAC and FP. Medical supplies and drugs stock outs are common. Whilst Misoprostol is registered for PPH, Mifepristone is not registered. Furthermore stigma and negative attitude from health workers were key barriers mentioned by most respondents, but also health workers being stigmatized for providing PAC. Some respondents emphasised that this is becoming less of an issue nowadays, whilst others indicated that health workers sometimes chase women away who come for abortion or PAC, out of fear and unawareness. Due to the lack of access to safe abortion, many women go to TBA's, or a "quack" for unsafe abortion. Some respondents expressed that the national political level is not supportive, but at local government level, where the weight of the problem is more felt, there is more support.

Perceptions and beliefs around issues of safe abortion were mentioned to be major issues in the society, and there is a lot of stigma towards women who request abortion, as illustrated by the following quote:

"Now the public only looks at abortion from a moral angle. They think that the person who procures an abortion is inhuman, is a criminal, things like that. And there are those ones who think that if abortion is legalised, it will increase prostitution and it will generally increase the moral decade of society. And there are those ones who look at it from the cultural angle like the religious leaders who think that sex is a recreation..." (Key Informant)

Due to the restricted legal and policy environment many abortions are not reported, or reported as PAC, however, respondents gave various indications for the scale of the problem. One believed there are 800 unsafe abortions in the country every day, and another interviewee said that about 5 women die per day due to unsafe abortion and that 24% of maternal death in Uganda is due to unsafe abortion. Some gynaecologists working in the emergency ward revealed that often up to half of the patients they see, come with complications due to unsafe or incomplete abortion. Adolescents were mentioned as a key group of concern by most interviewees.

Methods used for unsafe abortion include the use of sharp objects, like safety pins, nails or knives, hangers, or using sticks, Omo detergent, Jik liquid or herbs. Complications from unsafe abortion are very common and extreme (eg. Permanent injuries to or loss of uterus, death) and the demand for PAC is high.

"I remember a 16 year old girl requesting for abortion. I tried to tell her to keep the pregnancy. When she left she said I did not help her. Later I was called to the emergency ward, it was the same girl. I operated on her 6 hours, she survived but lost the uterus. I wonder what the quality of her life is." (Gynaecologist)

One respondent grouped the consequences of unsafe abortion into physical (infection, bleeding), psychological trauma, social problems ("if you tell someone that you have aborted, socially you are not

acceptable in society, that you have killed a foetus or things like that”) and economic consequences. Catholic, Protestant church and Muslims were mentioned as strong opponents.

“I witnessed two cases where girls came in with perforated uterus. One remained on the ward for almost two weeks but unfortunately she passed on because by the time she came in, she was actually what we call ischemia, the whole body was infected because of the abortion. The uterus was gone, so we had to remove the uterus. She came in with a grandmother and it was this poor family, it was terrible. It was a kid I will never forget her... She lost the uterus but she died after showing signs of recovery, unfortunately we lost her. Another one luckily enough also she came but immediately after perforation, we had to remove the uterus and she survived. But you can imagine what is very disturbing is some of them try to seek for the safe abortion which cannot be provided. But because they cannot receive it they go ahead and seek for the unsafe abortion and that gives them complications.” (Gynaecologist)

4.3.2 Position on safe abortion by different institutions

AOGU’s position on safe abortion is not unanimous and not clear for all members. Answers varied between the key informants from the association. Key informants revealed that AOGU has taken the official position to not support safe abortion, based on a mini-survey among members, which revealed that the majority of members were not in favour of supporting safe abortion, but that AOGU is supportive to all activities related to abortion including advocacy, harm reduction, PAC, prevention of pregnancy, and counselling.

“I doubt that even AOGU has a position, so you are never sure what stand to take as they don’t want to be seen to stand on the wrong side of the law. So it is difficult, somehow it is highly political and polarizing.” (AOGU member/Gynaecologist)

- Ministry of Health, as a government department is officially not supporting safe abortion, the key informant pointed out the issue of the retracted SRHR guidelines by the Minister of Health, who said ‘we cannot have maternal mortality reduced by safe abortions.’
- CEHURD has a clear position; ‘no woman no girl should die due to lack of reproductive health, we are prochoice, it is a comprehensive approach.’
- IPAS doesn’t condone abortion. Their vision is that if you must have an abortion then it must be done in a safe environment by a qualified health worker to save the life of the woman and that girl.
- Population Secretariat is a government institution and aligns with the government position that abortion is illegal.
- Makerere University doesn’t have an official position. Whilst sensitization about safe sex is done among students, there is no mentioning of abortion at all.
- College of health sciences also don’t have their own position on safe abortion and aligns with the government position of abortion.
- Ministry of Gender: Don’t have an official position, but generally not in favour of liberalizing the abortion laws, focus more on prevention of unintended pregnancy

4.3.3 Personal position on safe abortion

One key informant highlighted that it is very difficult to generalize about people's position on safe abortion, because of the restricted law, people don't openly speak out their opinion.

Except for one key informant who said that abortion is murder, many key informants felt that safe abortion should be available for women, but often did make a difference depending on circumstances. Some key informants, who were leaning towards opposing liberalizing the laws would argue that for example if a teenage girl is raped, at first the pregnancy is a shock, but once the baby is born, everybody is happy. The focus of these key informants was on preventing unintended pregnancy (although, not through making contraception available for adolescents, but tell them to abstain) and better psychosocial care for rape survivors, rather than on safe abortion. Several interviewees felt that introducing the law to allow abortion is not the right thing now, and that it would be perceived as 'transplanted from somewhere'. One key informant said that providing abortion in the hospital is difficult for him/her, but he/she would provide information about how to take the medicine, or refer for MVA to a known healthcare provider who can do this safely. All respondents agreed that PAC is important and should be provided, even those opposing abortion.

"PAC is healthcare like another. We have to treat them well. We treat somebody who has been speeding, so why do we discriminate people who had an abortion. I think in my Christian faith I have enough justification to promote sympathy for people who had an abortion." (Religious leader)

4.3.4 Relationship between professional societies

There were several consortia, NGOs, civil society organizations and women's organizations, mentioned as important partners, and to some extent being involved in safe abortion advocacy, such as: The Uganda Organization of Women's Lawyers (FIDA), Centre for Women In Governance (CEWIGO), Association for Women Medical Doctors, AOGU, IPAS, IPPF, Marie stopes, Reproductive Health Unit Uganda (RHU), Pace, SCMUA, and CEHURD, and Voices for health, led by Uganda National Health Consumers Organization (UNHCO), a consortium of civil society organizations advocating for maternal health issues. Whilst there are several actors and initiatives, the advocacy efforts seem to be fragmented, and respondents indicated that relationships between professional entities could be strengthened.

AOGU was well appreciated by key informants from other institutions, but it was generally emphasised that collaboration is based on individual initiatives and not consistent. For example, AOGU has a good working relationship with MOH, and is involved in revision of the guidelines, but it is more on an individual level, rather than a representation carried by the association. The same was mentioned about AOGU's relationship with CEHURD. AOGU also engages with Members of Parliament to raise awareness about safe abortion.

Ipas works closely with MOH and Uganda Law Reform Commission to advocate to work on streamlining the policy and the law because there are amendments that need to be done. Ipas is also engaging the Uganda Journalists Association, aiming for responsible reporting, and working with Parliament identifying and supporting champions.

4.3.5 Level of influence

Due to the strength of religious and cultural leaders and legislators, it was felt by some key informants that the level of influence of the safe abortion advocates is limited. But also because of the strong societal beliefs in having big families.

AOGU was seen as influential by some, and others felt they have good potential to be more influential, especially through the work of champions like Dr. Charles Kiggundu and his team, who are the voice of the association, and a lot of the advocacy work on safe abortion seems to depend on individuals like Dr. Kiggundu, rather than

it being driven by AOGU as a society. It was felt that that advocacy from the entry point of service delivery is powerful and influential, as AOGU is doing. But it would be stronger if various organizations join efforts. CEHURD is seen as influential as human rights lawyers and engage with politicians from a legal angle. IPAS was mentioned as influential as they provide the scientific relevant input to support the work service delivery and human rights based approaches.

Yet, there is still a very challenging environment for advocacy on abortion. One gynaecologist highlighted some of the challenges faced:

“We got into a political storm when we were proposing that adolescents should be a focus in a country where 25% of women who deliver are adolescents [...] we thought that we should actually focus on adolescents and give them protection and then we wrote a policy document and these people said, ‘honourable minister these doctors want to give children pills’; leading article on the newspaper ‘doctors want to prescribe pills for children’, religious people, catholic church got everybody in arms and we have the policy suspended” (Gynaecologist)

4.3.6 Opportunities for strengthening safe abortion network

Several opportunities were highlighted which could strengthen the safe abortion network. First of all the majority of respondents felt that it is important to bring everyone on the same table and come with one stance as AOGU. It was felt that through the membership of AOGU and addressing safe abortion advocacy with them and through them is an opportunity. Especially because the members of AOGU are witnessing the consequences of unsafe abortion and the needs for safe abortion every day in their work as gynaecologists. It was felt that there is a major need for improved dialogue as one of the key informants called it “positive advocacy”, meaning that advocacy needs to start with engaging the population, making sure they understand, and address social perceptions first, before advocating for a change in the law. It was further emphasised that a transition needs to be gradual rather than pushing for a sudden change, which will create resistance). AOGU should come with a very strong message on what is currently happening in terms of abortion in Uganda, and what the consequences of abortion and what happens if we do nothing about it. It was highlighted that sensitivity in framing safe abortion advocacy and selecting words that can be accepted is very important as illustrated by the following quote:

“You cannot include the word ‘comprehensive sexuality education’. The words almost caused an uproar. You can’t put it there, deleted if the programme has to continue. Now, talk about abortion openly like that! People will say ‘these have just been given money, they want to come and spoil our people here’.” (Researcher)

The issue of lack of information from research and routine data to show the real extend of the problem was highlighted by several key informants, stating that HMIS doesn’t provide for proper reporting on safe abortion and it only documents what patients said, which is often far from the truth. Showing the real extend of the problem will be a good opportunity for advocacy. Not only from a medical point of view, but also show that abortion is a social issue as well. Furthermore, it was seen as an opportunity to bring the various actors together, including young people. AOGU is seen as in a good and respected position to mobilize together with Ipas, CEHURD, and work with MOH.

4.3.7 Current role in safe abortion advocacy.

As outlined in the above sections, most respondents feel that their role in safe abortion advocacy is focused on prevention of unintended pregnancy and ensuring PAC is available, and only few respondents feel that their role is to advocate for safe abortion and law reform directly. Also within AOGU these sentiments are divided and there is no coherent role that the association takes in a uniform matter. Also Ipas sees their role predominantly in sensitization, capacity building of the health workers and also liaising with government to find a middle ground, a win-win situation to save the lives of the mother. The key informant from MOH felt to be in a difficult position because of working for government, so the advocacy role is limited to mainly listening to people, and not taking sides. There is no working group or committee within MOH leading the work on safe abortion.

4.4 Stakeholder workshop

The workshop was attended by members of AOGU working at Mulago, Soroti, Mbale, Masaka and Mbarara hospital, Naguru teenage Centre, Marie Stopes Uganda, JHPIEGO, Busitema University, and Ministry of Health. During the workshop the key themes which were emphasized evolved around the challenges faced in relation with the **restricted legal dimensions**, the **service delivery environment**, the **norms and values** at various levels of the society, including those of **health professionals**, as well as the need for **evidence for advocacy**. **The network for safe abortion advocacy and the capacity of AOGU** to take the lead in advocacy was debated. The needs of **adolescents** was a crosscutting issue. The dilemma of health providers, who witness the needs of women who request for abortion, or those who come with complications after unsafe abortion in a restricted legal environment was the overarching topic of this workshop.

“Yesterday I received a 17 year old who was impregnated by a sports teacher. She did not want the headmaster and parents to know. In this meeting I expect a lot to learn – am I protected, am I doing the right thing, what are the consequences?” (Gynaecologist)

The emphasis was made by AOGU that comprehensive abortion care includes 4 dimensions; 1) prevention of unintended pregnancy in the first place; 2) ensuring that abortion is done in a safe way when there is a need; 3) provide PAC for women who have gone through an abortion and 4) provide contraception immediately following an abortion to avoid a repeat of unintended pregnancy. In light of this continuum of care, key points were highlighted, which can be found in annex 3. These will be addressed in the action plan.

4.4.1 Social Networks

During group work social networks for safe abortion were identified. Annex 4 provides a summary of allies and networks where potential allies could be found. This should be seen as a dynamic table. Along the way new allies can be identified and potential allies can move.

4.4.2 Strengths, Weaknesses, Opportunities and Threats

The main outcomes of the SWOT analysis can be found in Annex 5.

4.4.3 Action plan

As a final exercise, groups started on defining objectives and activities for an action plan on safe abortion advocacy. The action plan has the overall objective to improve the capacity of AOGU in abortion advocacy with the ultimate outcome that women have increased access to safe legal abortion. Activities should serve to reach the objectives and will include the different advocacy levels and social networks addressed during the workshop.

After the stakeholder workshop the consultancy team continued to develop the action plan, including deliverables. The action plan will continue to be developed in consultation with AOGU and FIGO.

A preliminary action plan can be found in Annex 6.

5. Conclusions

The literature review, the key informant interviews and the workshop confirmed that unsafe abortion and its complications is a major problem in Uganda, endangering the lives of many women. The restricted abortion law, the absence of a supportive policy environment as well as cultural and religious beliefs, make it extremely challenging to provide safe abortion services or even openly discuss the issue.

This study highlights some of the challenges that face safe abortion advocacy.

- **The restrictive laws for safe abortion** in Uganda. The law has not been updated since 1950 and allows only abortion to save a woman's life. The interpretation of this law is challenging, as it has not been defined what life saving means. Health workers, including AOGU members feel restricted by this law and fear for legal implications of providing safe abortion or advocating for improved legal dimensions.
- **Absence of policies and guidelines on safe abortion:** the withdrawal of national SRHR policy guidelines, which was more liberal than the law, allowing safe abortion also in cases of rape and incest and the withdrawal of the adolescent health policy, which included provision of contraception for adolescents has left health providers empty-handed. There are no national guidelines which describe safe abortion procedures.
- **Strong opposition:** There are many influential people and groups opposing safe abortion, including some very influential political leaders, like the first lady, which restricts also the influence of the Ministry of Health to allow liberalized policies. Religion and **sociocultural norms and beliefs** are strong. Churches and **religious leaders** have a major impact on the public debate and perceptions. Not only about safe abortion, but also about **prevention of unintended pregnancy**, like making **contraception available for adolescents**.
- **Opposing standpoints/views within AOGU:** AOGU's advocacy efforts for safe abortion depends heavily on individuals. There is no uniform positioning by AOGU as an association on safe abortion. The understanding of and preferred approach to safe abortion advocacy varies significantly between members and between AOGU's leaders. AOGU's capacity for advocacy is compromised by these conflicting views, as well as by financial constraints, lack of skills among members.
- **Unsafe or secret abortion services:** health providers are confronted with an enormous demand for post abortion care as a result of unsafe abortion. Health workers are facing the dilemma of referring women who request abortion to secret abortion services and nobody can openly talk about these services.
- **Lack of data on safe abortion:** There is a need to present data and facts about the needs for safe abortion and the consequences of unsafe abortion, but this information is not collected as there is no legal protection to provide these services openly and systematically collect data.

To strengthen advocacy for safe abortion requires the engagement of various stakeholders in dialogue to win them over. AOGU's strong presence as a leader in technical knowledge has the opportunity to influence and network with like-minded organizations to advocate for and provide safe abortion to women who require the service.

6. Recommendations for future program

Building its base as a safe abortion advocate, AOGU will require to address the various and potential challenges as were identified during the key informant interviews and the two day's workshop. This could include the following:

- Strengthening the management and organization of AOGU in their capacity of safe abortion advocates
- Establishing a coordinated and vibrant network of associations that are supportive of safe abortion
- Transforming the social and gender norms at all levels regarding safe abortion but within the context of the Ugandan law
- Ensuring that the policy environment is conducive and provides a framework for health workers to provide safe abortion care without fearing legal implications
- Ensuring a process for data generation and use for monitoring and planning for services

Our prayer is that one day women have their full rights realized, we give them rights with the right hand and withdraw them with the left hand. They have the right to decide when to get pregnant, but not when they don't want the pregnancy. (Gynaecologist)

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Annex 1 Program and participants of stakeholder workshop

Time	Content	Facilitator
Day 1		
8.30– 9.10	Welcome and Introductions Getting to know each other, expectations, purpose, objectives, agenda, facilitator's participant roles, group norms, evaluation process, housekeeping	Dr. Kiggundu Bianca Jenipher
9.10-10.20	Presentation preliminary country results; validation of analysis; Dialogue about reasons for abortion and what needs to improve to meet women's need for safe and legal abortion	Jenipher Dr. Kiggundu
10.20-10.35	Break	
10.35 -11.00	Presentation and discussion results of group work dialogues	Jenipher Musoke / Bianca Tolboom
11.00-11.30	Implications of national abortion laws on access to safe abortion.	Jenipher Musoke / Bianca Tolboom
11.30-12.30	Share positions and personal beliefs and discuss professional responsibilities	Jenipher Musoke / Bianca Tolboom
12.30-13.30	Lunch	
13.30-14.00	What is advocacy: concept, levels and challenges	Jenipher Musoke / Bianca Tolboom
14.00 -14.30	Advocacy perspective, risks and benefits in advocacy	Jenipher Musoke / Bianca Tolboom
14.30-15.00	Roles in advocacy	Jenipher Musoke / Bianca Tolboom
15.00-15.15	Break	
15.15 -16.00	Roles in advocacy continued	Jenipher Musoke / Bianca Tolboom
16.00-16.25	Power dimensions in advocacy (Skipped due to time constraints)	Jenipher Musoke / Bianca Tolboom
16.25-17.15	Advocate for safe abortion care	Jenipher Musoke / Bianca Tolboom
17.15 –17.30	Evaluation of the day	Jenipher Musoke / Bianca Tolboom
Day 2		
8.30-9.00	Welcome Recap of day 1 by 2 volunteer participants identified day before	Two volunteers
9.00-10.00	Social networks and reaching different audiences	Bianca / Jenipher
10.00-10.30	Break	
10.30-11.00	Address parked issues	Bianca / Jenipher
11.00-12.30	Presentation of achievements weaknesses barriers and opportunities of abortion project. Then: strengths, weaknesses, opportunities and threats of the national society for abortion advocacy.	Dr. Kiggundu
12.30-13.00	Lunch	
13.00-15.00	Develop an action plan for abortion advocacy in small groups	Dr. Kiggundu / Bianca / Jenipher
15.00-15.15	Break	
15.15 -16.00	Continue develop action plan	Jenipher Musoke / Bianca Tolboom
16.30-17.00	Presentation and discussion action plans in plenary	Dr. Kiggundu/ Bianca Jenipher

17.00-17.30	Evaluation and goodbye	All
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Elaboration on Content of the workshop

The workshop contained eight components:

1. **Introduction:** a session where the background and objectives of the needs assessment and the stakeholder workshop were explained, logistics of the facilitations process, roles and group norms were discussed. Dr. Charles Kiggundu opened the day and gave an introduction to AOGUs work on safe abortion advocacy.
2. **Presentation of draft country results and identification of women's needs for safe and legal abortion:** a session where the preliminary results of the desk review on country background, legal and political context, abortion stigma, service delivery environment and advocacy activities in the country were presented and validated with the participants. In a second part of the session case studies about women having obtained unsafe abortion were discussed and analysed in groups. Needs from the perspective of the woman were identified with respect to availability, access to and quality of safe abortion services, environmental and legal dimensions.
3. **Share positions and personal beliefs; discuss professional responsibilities:** a session where personal barriers and motivations to provide safe abortion were explored, with the emphasis that everybody has a right to personal beliefs, which are not questioned. Personal beliefs were benchmarked against professional responsibilities and FIGO's resolution on conscientious objection was discussed in the light of remaining barriers (such as limited professionals available in the country).
4. **What is advocacy and why providers as advocates:** a session to define advocacy and emphasize health providers' unique strength for advocacy, based on: first-hand experience, trustworthiness, extensive network, intermediary client-provider, prestige and status.
5. **Three roles of an advocate:** a session to explore one's advocacy role as an educator, witness or persuader within different advocacy scenarios: provider-client, provider-provider, provider-professional network, provider-media, provider-policymaker.
6. **Social networks and reaching different audiences:** a session to explore social networks for advocacy on safe abortion, identify current and potential allies and ways to reach them.
7. **Strengths, weaknesses, opportunities and threats (SWOT) analysis:** to the abortion advocacy capacity of AOGU.
8. **Development of an action plan:** a session to, based on the outcomes of the previous session components, identify objectives and activities for the next proposal on safe abortion advocacy.

The following sources were used for development of the workshop activities:

- Ipas | Providers as advocates for safe abortion care: A training manual. 2009 http://www.ipas.org/en/Resources/Ipas_Publications/Providers-as-advocates-for-safe-abortion-care-A-training-manual.aspx
- Ipas | Abortion attitude transformation: A values clarification toolkit for global audiences. 2011 <http://www.ipas.org/en/Resources/Ipas%20Publications/Abortion-attitude-transformation-A-values-clarification-toolkit-for-global-audiences.aspx>

Participants of the workshop

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20	Nabatanzi Stella	Finance Officer (workshop support)	0702317927	nabstella@hotmail.com

Annex 2 Key points from stakeholders workshop

1. Law and policy:
 - The law is restrictive and old (1950)
 - The SRHR policy is not in line with the law and was retracted, there is an opportunity to work on the update of this policy
 - There are key influential politicians, who are not allowing the law and policy to be more liberal for safe abortion
 - The population is unaware of their rights
 - Health providers don't feel protected and fear the consequence
2. Service provision:
 - Major burden on health workers and the health system due to high need for PAC
 - Safe abortion not available, referral to individuals in private sector or outside health system
 - Stigma and attitudes of health workers also due to own religious and cultural believes
 - Abortion is an income for health workers (so, may not be interested to legalize it?)
 - Midwives need to be empowered and trained to provide safe abortion care
 - Lack of skilled personnel to provide safe abortion care
 - Access to services for adolescents very difficult, lack of youth friendly services
3. Social and religious traditions and believes:
 - Religion is a big influence for the population and a barrier for access to safe abortion, but also other SRHR services, such as contraception for adolescents
 - Cultural believes, like having big families are highly valued, issues like contraception and safe abortion are frowned upon.
 - Lack of agency of women, and patriarchal society, leading to a situation whereby women can't control sex.
 - There is a lot of misinformation about services, the law and rights of women, and consequences of unsafe abortion.
 - Health education and dialogue about comprehensive abortion care, with community and TBA's is needed
 - Important to package messages well, focus on prevention, FP, CAC, otherwise people will not be on board
4. The social network
 - It is important to work with media
 - It will be good to sign an MOU with MOH, more broadly on SRHR, providing an entry-point to discuss abortion.
 - It is important to work with religious leaders
 - Strengthen network to be stronger abortion advocates together
 - Ensure a Comprehensive Abortion Care (CAC) approach which also focusses on prevention of unintended pregnancies and unsafe abortion.
5. Evidence for advocacy
 - Importance of the use of facts and data for advocacy purposes
 - Therefore need for research
 - Inclusion of abortion related questions in DHS
 - Systematic collection of health information at clinics (HMIS)
6. AOGU's capacity as advocates for safe abortion:
 - Members of AOGU have varied opinions about safe abortion and the role of AOGU in advocacy
 - Current advocacy efforts depends on individuals, not owned by AOGU as an association
 - There is a training need on advocacy among members
 - There is a need for values clarification among members
 - It is important to package the advocacy messages well and maneuver within the peripherals of the law
 - There are financial constraints to effectively focus on advocacy

Annex 3: Overview of outcome online survey

The summary of responses to the online survey comes in an additional file, in PowerPoint format.

Annex 4 Social Networks

ALLIES	POTENTIAL ALLIES	OTHER STAKHOLDERS
Marie Stopes Uganda (MSU)	MOH (Ministry Of Health)	
Population Services International (PSI)	FIDA (Federation of Women Lawyers in Uganda)	U PEAD ASSOC (Uganda Pediatric Association)
Reach A Hand Uganda (RAHU)	CULTURAL LEADERS	Uganda Nurses and Midwives Union (UNMU)
Centre for Health, Human rights and Development (CEHURD)	RELIGIOUS LEADERS/Church	ACADEMIC INSTITUTIONS
THERWODDE	FIRST LADY	RHU (Reproductive Health Uganda)
Ipas	PHYSICIANS ASSOCIATION	CULTURAL LEADERS
Human Rights Advocacy and Research Foundation (HRARF)	JUDICIARY	MOE (Ministry of Education and Sports)
Uganda Parliamentary Women's Association (UWOPA)	UMA (Uganda Medical Association)	MIN OF GENDER
AKINA WA MAAMA AFRIKA	JOURNALISTS	THETA (NGO, dedicated to improving the health of Ugandans by promoting collaboration between the Tradition and Biomedical Health Systems.
Coalition to Stop Maternal Mortality due to Unsafe Abortion (CSMMUA)	PARLIAMENT COMMITTEE ON HEALTH	SECRETARIAT MOH, PARTNERS EG WHO, UNFPA, DHO, LC5
Uganda Private Midwives Association (UPMA)	INTER RELIGIOUS COUNCIL	Police
	MEDICAL BUREAUS	Women's Organization Network for Human Rights Advocacy (WONETHA)

Annex 5 SWOT analysis

SWOT analysis of national society capacity for safe abortion advocacy	
<p>Strengths</p> <ul style="list-style-type: none"> • Professional organisation with skills and technical knowledge • Command respect in terms of RH, training and research • Have country wide representation from different regional hospitals and general hospitals • Champions in Reproductive Health in the country • Members are the witnesses of consequences of unsafe abortion • Good knowledge and understanding of different stakeholders • Have good experience in advocacy and existing advocates in the groups • Important link between clients and stakeholders • Have data and evidence which can be used • Clinical experience of the members • Credible in reproductive health services, training and research • A good working relationship with Ministry of Health, partners in reproductive health (eg. UNFPA, WHO, Marie Stopes) • Country wide representation 	<p>Weaknesses</p> <ul style="list-style-type: none"> • Not that financial muscle to equip themselves in a better position to advocate • Limited advocacy skills among members • Level of knowledge of advocacy is limited among members • Very many competing priorities • Legal interpretation of the law needs to be adjusted • Lack of influential allies • Lack of a unified stand/position on safe abortion
<p>Opportunities</p> <ul style="list-style-type: none"> • This safe abortion needs assessment and survey – will help to get a clear position on safe abortion for AOGU • Engage stakeholders, which AOGU can do as leaders in RH services • AUGU has the data and experience, so needs to take lead in showing burden and magnitude of the problem. • AOGU can provide an enabling environment for the population to demand for services, bring on politicians, religions leaders as long as well packaged messages are used. • There is existing allies in action and AOGU has contacts with most stakeholders • Public demand for the service because women continue to have unsafe abortions and there is a high maternal mortality. • Male involvement – Uganda has been making thrives in having men involved in women matters. • Involve media to propel and inform the population can demand for the service and politicians can amend the law 	<p>Threats</p> <ul style="list-style-type: none"> • Restrictive legal framework and laws of the country • Cultural and religious norms and values of population • Political environment difficult to take a position • Hostile media, not on our side • Lack of consensus among AOGU members

Annex 6 Country action plan

A preliminary country action plan will come in a separate file in excel format.