



FEMINIST APPROACHES TO ABORTION RIGHTS IN UGANDA



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Definitions

- Abortion: The World Health Organization (WHO) defines abortion as pregnancy termination prior to 20 weeks gestation.
- Anti-gender ideology: is an international movement which opposes what it refers to as gender ideology, gender theory, or genderism. 1
- Anti-gender movement: Is an international movement that opposes what it refers to as “gender ideology”, “genderism”, “gender-theory”
- Conscientious objection: The refusal to participate in an activity that an individual considers incompatible with their religious, moral, philosophical, or ethical beliefs. 2
- Feminism: Advocacy for women’s rights on the ground of the equality of all sexes. It includes the idea that women and men should have equal legal and political rights, sexual autonomy, and self-determination.
- Autonomy: in the feminist sense is the ability to act on motives, reason, or values that are one’s own- self -government or self- direction. 3
- Bodily autonomy: is about the right to make decisions over one’s own life and future. It is about being empowered to make informed choices. 4
- Self-determination: the free choice of one’s own acts without external compulsion. 5
- Agency: the capacity/ability to make an individual choice or act on something. It is usually dependent on prevailing norms and one’s background. 6
- Patriarchy: A social system in which men hold primary power and predominate in roles of political leadership, moral authority, social privilege, and control of property. 7
- Feminist theory: Is a major branch within sociology that shifts focus away from the viewpoint and experiences of men towards that of women instead. In so doing, feminist theory shines light on the social problems, trends, and issues that are otherwise overlooked or misidentified by the historically dominant male perspective within social theory. 8

Background

Akina Mama wa Afrika, in partnership with the Joint Advocacy Program on Sexual and Reproductive Health and Rights, has developed this technical paper on feminist approaches to abortion rights in Uganda to contribute to the discourse of feminist analysis and intersectional organizing. This document will also contribute to the existing body of knowledge that seeks to interrogate the relationship between the current social-cultural norms, legal and policy facets on abortion, and their impact on the lived experiences of women, girls, and gender-expansive persons in Uganda in the quest for realization of their rights to bodily autonomy, self-determination, and agency.

Executive Summary

Abortion rights in Uganda have been discussed extensively by different groups, however, there is still a dearth of information and praxis on how feminist theory may be leveraged to facilitate advancement of abortion rights. This scarcity continues to be perpetrated by the parallel and siloed manner in which the women's movement, the sexual and reproductive health movement, and other sister movements are addressing the issue of unsafe abortion as not only a reproductive justice issue but also a gender justice issue.

Feminism emerged as a response to the historical and systemic oppressions that women faced, and the struggle for abortion access is no different. With the struggle for the rights of women and girls, came open opportunities for women and girls' empowerment; women and girls were able to gain access to formal education and participate in areas outside their traditional roles, and this journey continued long after independence leaving African countries to achieve self governance status. Schools for women were opened, both for formal education and technical training; women were able to acquire an education that saw many employed as secretaries, clerks, nurses etc. Education and other basic social services programs such as the Ugandan government's 1980s Recovery Program included expansion and introduction of appropriate technologies that reduced women's workload in the fields and at home so that they were able to have more time for participation in other activities and healthcare including maternal health and planned parenthood.

Despite this progress, the much-revered formal education has been a double-edged sword that has entrenched gender stereotypes and practices which have continued to discriminate against women and girls in their diversities. For instance, the colonial

legacy of lower cadre health work being typically reserved for the female gender – a practice that is still prevalent in Uganda and the global south at large. It is undeniable that the historical footprint of colonialism is still an issue to contend with in how it has perpetrated gender inequality, including around access to services such as reproductive healthcare Nansubuga (2011) Young Women, Empowerment, and Development in Sub-Saharan Africa (including family planning and safe abortion). This can in part be attributed the history of societies, which for countries like Uganda includes the legacy of colonialism and its civilizing entry points that majorly comprised education, health, and religion.

This paper analyses the facets of law, culture, religion, economics, and the politics of the day, and how they have colluded to ensure that the realization of women's and girl's rights (with a focus on the reproductive choice and agency thorough abortion access) remains aspirational and not reality.

It utilizes an African feminist lens to unpack how Uganda's history has interplayed with other actors to ensure that women and girls remain subjugated in reproductive roles as nurturers of children and society. This has created a socially burdened human being who may not be able to favorably compete in other spheres of life including professions like education, athletics, and even politics. In trying to unpack the politics of abortion, the non-homogenous nature of women is an important consideration to be borne in mind.

The value of infusing African feminist principles into the struggle for abortion rights presents an opportunity that the women's rights movement and sister movements ought to leverage. This includes being able to realize abortion rights for all women and girls in their diversity as a multi-sectoral and intersectional task that can be advanced through intentional efforts. The fight for safe abortion access has hitherto been the preserve of the reproductive health movement and health workers; one of the missing links towards destigmatizing safe abortion access is the silence about women and girls' lived experiences as they seek safe abortion care and other reproductive health services. Stigma serves to maintain society's hold over the lives and bodies of women and girls because, indeed, the personal is political. Safe spaces should be created where women and girls can share their stories in a non-judgmental manner with no fear of being criminalized or ostracized.

Methodology

Mixed methods were utilized to obtain relevant data on safe abortion access and rights in Uganda and other comparable jurisdictions regionally and globally. Key resources reviewed include legal and policy analyses on abortion as well as feminist literature and analyses on reproductive health, justice, and their intersection. Various new media platforms including blogs, podcasts, and online news platforms were also reviewed to glean contemporary discourse around abortion rights and feminism. Feminist theory and its underlying principles were used to interrogate political, social, and economic structures and how they intersect with women's ability to exercise abortion rights.



Introduction

THE PROBLEM OF UNSAFE ABORTION IN UGANDA

Global estimates from 2010-2014 demonstrate that 45% of all induced abortions are unsafe, of which developing countries comprise 97%. In Africa, the majority (approximately 3 out of 4) of all abortions are unsafe.

Unfortunately, in Uganda, unintended pregnancies are common. The Uganda Demographic and Health Survey 2016 indicates that over 46% of pregnancies in Uganda are unintended, leading to high numbers of unplanned births and termination of pregnancies. Many of these terminations are unsafe, leading to debilitating injuries and even death of women and girls alike. The abortion rate for Uganda is slightly higher than the estimated rate for the East Africa region, which was 34 per 1,000 women during 2010–2014.

The physical and health risks associated with unsafe abortion include incomplete abortion (failure to remove or expel all pregnancy tissue from the uterus), hemorrhage (heavy bleeding), infection, uterine perforation, damage to the genital tract and internal organs secondary to insertion of dangerous objects into the vagina or anus.

Health facilities in Uganda treat complications arising from unsafe abortions totaling 15 of every 1000. Given the criminalization of abortion, many women silently suffer complications in their communities without seeking care. Unsafe abortion continues to contribute significantly to maternal deaths in Uganda. The Ministry of Health estimated that 8% of maternal deaths were due to unsafe abortions.

It is worth noting that adolescents and young women are particularly at risk for unintended pregnancies. In Uganda, young women (ages 15–24) are especially vulnerable, mirrored by the fact that 50% of all unsafe abortions in the region occur among women in this age group. Even though death and injury from unsafe abortion is highly preventable, there are a number of factors that collide to make women and girls in Uganda unable to access safe abortion services despite the legal, policy, scientific and normative human rights developments that have taken place globally to mitigate these factors.



THE LEGAL AND POLICY FRAMEWORK ON ABORTION IN UGANDA

Uganda's legislation on abortion stems from an outdated law created by the British colonial government, as is the case in most formerly colonized African countries. The British had themselves criminalized abortion in 1861 and, upon making Uganda a protectorate, all their laws, doctrines, and statutes became law in Uganda too. The common word was "unlawful", indicating that there was in fact room for lawful abortions. Interrogation of how abortion is regulated by law is important, mainly because unsafe abortion stems from the criminalization of abortion in many countries in Africa and remains a major health and human rights challenge.

The British themselves have since moved on from this law and progressed positively. In 1995, Uganda promulgated a new constitution and instituted Article 22(2) which provides that no person has the right to terminate the life of an unborn child except as may be authorized by law. In Uganda, abortions are legal only if the mother's life is endangered by the pregnancy such that an abortion is necessary to save her life. This Article states the impact of trends in the developed world and how countries like the United States of America influence countries like Uganda given that much funding for reproductive health and rights programs comes from Western donors. A clear example would be the Geneva Consensus Declaration, signed in Washington DC in 2020, establishing a formal united coalition in opposition to the United Nations' Universal Declaration of Human Rights which forms the basis for the definition of human rights under international law (including the right to abortion). This declaration was co-sponsored by Uganda and one other African country. The United States' position was that there is no international law on the right to abortion thus the United Nations should respect individual countries' laws and policies on the matter. It comes as no surprise that African countries whose budgets are dependent on donor funding would side with a donor country's views.

As seen in other laws besides reproductive rights, African leaders are more likely to include in their countries' legislations similarly restrictive laws to please their donors. It also brings about the terrifying reality that reproductive rights and women's rights are fragile. The law in Texas among others and potential reversal of Roe v Wade legislation offers a premonition of a better-funded, more organized global abortion rights opposition movement.

Currently in Uganda as mentioned above, the law prohibits abortion except to save the life of the woman. At the drafting of the Constitution of Uganda (1995), Constituent Assembly member Hon. Joseph Mulenga moved a motion that, instead

of specifying the grounds in Article 22, the clause should read, “No person has the right to terminate the life of an unborn child except as may be authorized by law”. This provision is an embodiment of the recognition by the Constituent Assembly that a clearer law is needed. On one hand there is a requirement for expanded abortion access in Uganda, and on the other an obligation to legislate regulation of the termination of pregnancy under Article 22(2). This, however, has not yet been done and human rights organizations have taken the Attorney General of Uganda to court to demonstrate findings that parliament has failed in this obligation.

The inconsistent interpretation of abortion laws persists amongst the general public, but perhaps of more significance is the inconsistent interpretation by health workers, law enforcement, justice organs, and the women and girls themselves. To further illustrate this point, the Ministry of Health of Uganda developed the 2006 and 2012 National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights which both clarify the grounds for access to abortion services to include pregnancies resulting from rape, non-viable fetuses, and persons living with HIV/AIDs. The Uganda Ministry of Health went further in 2015 by developing and launching the Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion. The aim of the document was to delineate a multisectoral approach by bringing together aspects of prevention and treatment in order to reduce death and disability due to unsafe abortions. Unfortunately, the implementation of these guidelines was stayed less than a year after the launch by way of a letter from then-Director General of Health Services.

The staying document stated, “since the release, a number of unforeseen issues have come up that require further discussions and guidance. This letter is to therefore request you to stay the implementation of the Standards and Guidelines for Reducing Maternal Morbidity and Mortality from Unsafe Abortion in Uganda until it is reviewed and endorsed by the Health Policy and Advisory Committee.” At publication of this guidance, said review and endorsement had not taken place and this document remains shelved.

The current law on abortion in Uganda (the Penal Code Act) also provides for a surgical operation under Section 224 and criminal liability is only excluded when the health worker advises for the procedure but not when the woman herself demands it. The interpretation of this is that a woman cannot request an abortion and that the Penal Code Act is not in touch with advancements in science given that

abortions are not exclusively surgical and can also be induced by oral medications such as misoprostol and mifepristone without need for any invasive medical interventions. The pervasive perception of illegality under Uganda's abortion laws has had a chilling effect, especially on the lives of women, girls and health workers. It continues to fuel stigma, fear, and secrecy which has driven the practice of abortion underground, forcing women and girls to take desperate measures often with deadly consequences. Even with the continued amendment of various laws and policies to address the emerging contemporary problems that Ugandans face, the continued criminalization of a health service applicable only to those capable of getting pregnant is truly one of the sustained forms of gender-based discrimination. As Professor Muhmoud Fathalla, a renowned professor and obstetrician-gynecologist said, "Women are not dying because of diseases we cannot treat. They are dying because societies have yet to make the decision that their lives are worth saving."



A FEMINIST ANALYSIS/ CONCEPT OF PATRIARCHAL IDEOLOGY

The Charter of Feminist Principles for African Feminists articulates that feminism places at the center of analysis patriarchal social relations, structures, and systems, which are embedded in other oppressive and exploitative structures. From this perspective, the decisions about the body – such as having children or not, when, and how many – pervade the relations of domination and inequality between cisgender men and women. For some, having children is a sign of masculine virility, production of heirs, and has everything to do with men's honor.

Prof. Fathalla put this quite aptly, stating, “Mothers have often been seen as means and not ends. Health services have been targeted to mothers to help them produce healthy babies, forgetting that there is a woman in the mother who also has a right to health and survival. Society has an obligation to fulfil a woman's right to life and health, when she is risking death to give life.” This dignity, respect, and fulfilment of her rights must extend to when she also decides not to carry a pregnancy to term.

It may be argued, therefore, that the value of a woman's life then derives from what she can do and offer society. Patriarchal power lies at the core of understanding abortion as a contested political issue and it consists of institutions, behaviors, ideologies, and belief systems that maintain, justify, and legitimize male gender privilege and power. Patriarchal ideologies and power structures shape policies concerning contraception, abortion, and sexual education, as well as the ability of a woman to make independent choices about the same. This has resulted in male-defined, male-dominated world views that are not informed by women's experiences such as pregnancy, childbirth, abortion, and gendered violence since these issues are not seen as a priority.

The invention of the oral contraceptive pill in the 1950s marked a watershed moment in women's liberation struggles as it gave women and girls the ability to enjoy sex without the fear of getting pregnant. The struggle to control women's reproduction did not end with the invention of modern contraception methods, however; even today, the Catholic Church continues to put up a formidable fight against the use of contraceptives under the view that they are tantamount to abortion – an argument that is not scientifically sound. This control extends to the qualifications that have been placed on who can access contraceptive methods that are customarily provided within what is commonly described as ‘family planning’ services. To this end, Braam and Hessini postulate that a feminism of development issues is necessary so that women's sexual and reproductive rights are seen as

central to sustainable human development agendas.

The male-dominated paradigm of development tells us that 1) abortion is not an important social issue, 2) abortion is immoral and wrong, as interpreted by religious gatekeepers, 3) abortion is culturally problematic as it challenges women's fundamental role and responsibility to bear children.

Contrary to the attempts by society to subjugate women, girls and gender-expansive persons and place strict constraints on their reproductive rights, the feminist approach has always centered the child bearer's bodily autonomy over any claim of rights of other parties like the fetus, the state, the non-birthing parent etc. This approach suggests that the final decision about a pregnancy's fate should solely be dependent on the birthing parent's supreme will.

Issues of reproductive agency are key in determining women's access to safe abortion in Uganda. Agency is the ability to make decisions and being able to influence one's own course of life. A study done at Mulago Hospital in Kampala to assess decision-making ability around sexual encounters, contraception, pregnancy/abortion found that women had little negotiating capacity as a result of economic dependency, thereby reducing reproductive agency. This in turn affects access to safe abortion.

Construction of womanhood plays a central role in shaping women's sense of self and ability to make decisions of their sexual and reproductive rights. Motherhood, culturally, is viewed as a core aspect of womanhood and has the following consequences: 1) Childbearing accords women status and a degree of personal power, 2) Women are under considerable pressure to become mothers, 3) Motherhood is seen as a natural process over which women should not try and assert control, and 4) Abortion, as a deliberate intervention to stop the process of mothering, is therefore seen as negative.

As women's choices have expanded in various spheres of life, their ability to exercise sexual and reproductive choices has not. This is due to patriarchal power which undermines women's confidence and ability to enjoy reproductive autonomy. Men have been socialized to make decisions and assert dominance. Women's lack of personal power to make decisions and choices about sex often plays a part in increasing the lack of access to timely and safe abortion.



CULTURE, RELIGION, AND ABORTION

Even before the coming of colonialism to Uganda and Africa as a whole, women and men were not viewed as equals – because of physical, social, or physiological factors. It is no surprise, therefore, that Selhausen and Weisdore observe that gender inequality also existed in indigenous social norms. The coming of colonialism and their agents simply further exacerbated this inequality in with regards to working skills, whether one was employed in the formal sector or informal sector, and other aspects like literacy.

Seggane Musisi postulates that the colonising triad comprising churches, schools, and hospitals were used as tools of control by the colonisers as this is where the seat of power dwelt in many African colonial states including Uganda. As such, women and girls seeking abortion care have historically been fettered or facilitated by these historical factors be it in the colonial or pre-colonial era. The impact of lack of access to safe abortion care can therefore in some way be attributed to one or all of the three pillars of colonial power and influence.

Whether yesterday, today, or in the future, the concept of patriarchy (which draws validity and sustenance from the dominance of the above three critical areas of life) is able to maintain its grip on the lives of women and girls. It is worth noting that abortion remains a universal phenomenon and there is no society where women have never had an unwanted pregnancy or attempted to terminate one whether successfully or not.

Even with societal control over their lives and health, during the pre-colonial era women used natural and traditional birth control methods, including coitus interruptus (withdrawal), prolonged breastfeeding, and the use of abortifacients. Many African societies used these tactics to avoid and delay pregnancy, thereby controlling their fertility. Abortion was and is still frowned upon in Ugandan culture since it is considered against nature and contrary to a woman's main objective on earth. Most terminations were done due to incest, premarital sex leading to pregnancy, etc., and were done by birth attendants and elderly women in the communities.

The historical criminalization of abortion in Uganda serves to curtail the right to exercise agency and therefore access to abortion services. Sections 141, 142, and 143 of the Penal Code Act define circumstances under which procuring an abortion is deemed unlawful. Section 224 provides for therapeutic abortion.

In 2003, a study was done to examine men's roles in determining women's access to safer abortion and post-abortion care, drawing on in-depth interviews with 61 women aged 18–60 and 21 men aged 20–50 from Kampala and Mbarara, Uganda. The data revealed a critical dissonance between women's reasons for seeking an abortion and men's perception of the same. The majority of men were of the prevailing belief that they could not support a woman in seeking post-abortion care because had the child been his she would not have sought a covert abortion; they therefore attached abortion to presumed promiscuous behavior by the woman. Given that money is critical in accessing safe and appropriate abortion care, the study shows that the lack of male support often proves fatal since it creates a financial barrier. This study, among others, concluded that involving men in abortion decision-making endangers women's lives.

Culturally, most men as heads of families are of the firm belief that it is their exclusive duty to decide when and how often their partners should have children. This explains why some women seek clandestine abortions in places that are untraceable for fear of consequences from their spouses and society.

The need to control women's reproductive capacity is hinged on two aspects: one is to institutionalize women's role as nurturers and the other is to maintain men's control over resources. A woman is seen as the property of a man and thus cannot make decisions when it comes to reproduction. It has been found that some health workers are more inclined to offer a woman an abortion when she goes to the facility accompanied by a man as the person that made her pregnant. It is also not uncommon to withhold emergency contraceptives from women who report to health facilities after experiencing rape, as they are required to convince the man in question to present himself at the health facility for tests including screening for sexually transmitted diseases. Even in emergency situations, women's rights to non-judgmental, timely, and high-quality care continue to be qualified and subject to the other gender's presence or absence as the case may be. Ultimately, enabling women's and girls' reproductive agency is about allowing women to reach their full potential so they can not only survive but also thrive and transform their lives.

As such, imposing motherhood onto women and girls and forcing them into bearing children they do not want reinforces the gender roles that society has placed on women: childcare and home care. This maintains the status quo of male dominance. It is no surprise, then, that medical advancements even from the colonial era have

been obsessed with the control of women's sexuality and advancement of men's vitality.

Many of these attempts to subjugate women span as far back as the pre-colonial era and continue to morph with the times. No matter if they are new or old forms, the impact on women and girls and their lives often produces similar results. One of the most salient examples of these struggles is that of bodily and decisional autonomy – and access to safe abortion. In the struggle for rights, a delicate balance must be struck to ensure that women are not further isolated and alienated – hence this interrogation should be cognizant of the possibility of further side-lining women and inadvertently letting off the hook other critical stakeholders who have a role to play in the realization of these rights.

This practice and stance are a direct contravention of women's and girls' right to bodily autonomy. As one of the critical building blocks of reproductive rights, women and girls' rights to autonomy has been a subject of debate the world over. The UN has thus developed a number of technical briefs and guidance for states on how this issue may be managed. The UN working group on the issue of discrimination against women and girls, citing the 2017 Human Rights Council Resolution on the elimination of discrimination against women and girls, acknowledges the backlash against women's rights to equality. It is within this context of rising fundamentalisms against women's rights that the working group decided to clarify its stance on termination of pregnancy by issuing a position paper. The working group noted that the right of women and girls to make autonomous decisions about their own bodies and reproductive functions is at the very core of their fundamental rights to equality and privacy. The council noted that the decision whether to continue or terminate a pregnancy is fundamentally and primarily the woman's decision, as it may shape her whole future, personal life as well as family life and has a crucial impact on her enjoyment of other human rights.

Religion has not only played a role in the legislative process but has also influenced reproductive decisions, thus influencing the legal and policy regime that regulates abortion access in Uganda and many other countries across the world. Noteworthy is the persistence of the penal provisions on abortion on Uganda's law books as highlighted previously. These were inherited from the British colonists as was defined under the English Offences Against the Person Act of 1861. And whereas different religious groups have varying stances on the issue of abortion, the Catholic

Church has established itself as one of the most prominent anti-abortion actors globally. This dates back to 1869 when Pope Pius IX declared that ensoulment occurs at conception. As a result of the Pope's view, the laws of many countries were changed to prohibit any termination of pregnancy and, in some cases, contraception. These are closely followed by right-wing religious fundamentalist groups who rely on the prohibition of murder by asserting that a fertilized ovum constitutes human life.

The Catholic Church to which many Ugandans adhere (approximately 40%) is in strong opposition of and takes a very conservative stance towards abortion. The Church outspokenly opposed Uganda's ratification of the Maputo Protocol, believing that the situations of severe distress mentioned in the protocol text (rape, incest, sexual assault) cannot create the right to suppress an innocent life. The Church remains a strong political force in Uganda and is not only able to sway the government but public opinion as well. The Article in the Protocol has been seen as straying away from Uganda's societal goals.

An example of the faith community's influence on the political arena in Uganda regarding abortion was manifested a decade ago when a set of teachers' manuals containing a chapter on safer sex to avoid abortions was introduced by the government. These had to be withdrawn from the curriculum within a year after having been strongly criticized by conservative and religious advocacy groups. Since then, Uganda's official position on sex education remains undefined. Such influence extends to safe abortion care and access. A salient discourse of religion is the sanctity of life: anti-choice activists from the Catholic Church have come out to declare abortion as "murder" and an "evil act." One of the Church's bishops was quoted as saying that enduring a pregnancy resulting from rape, having the baby, and the "joy" of motherhood would be the right therapy and the baby would learn of the mother's heroism. Here the man's role and responsibility is not problematized at all, and the woman's feelings and autonomy are not considered since having an abortion is seen as going against a woman's role in nature.

Looking at the Muslim community, however, progressive stances have been noted. Islam is considerably liberal concerning abortion, which is dependent on (i) the threat of harm to mothers, (ii) the status of the pregnancy before or after ensoulment (on the 120th day of gestation), and (iii) the presence of fetal anomalies that are incompatible with life. Considerable variation in religious

edicts exists, but most Islamic scholars agree that the termination of a pregnancy for fetal anomalies is allowed before ensoulment, after which abortion becomes totally forbidden, even in the presence of fetal abnormalities; the exception being a risk to the mother's life or confirmed intrauterine death. Such a progressive stance goes a long way in providing opportunities for women to have access to abortions.

The anti-choice movement has gained considerable ground, especially in ensuring that young women and girls do not have access to safe abortions. Teenage pregnancy is a crucial public health issue in Uganda where 25% of women in Uganda give birth before the age of 19. Efforts to curb this would include comprehensive sexuality education (CSE), family planning access, and access to safe abortion, among others. However, anti-choice groups have risen to create barriers to access. An investigation carried out by Global Open Democracy revealed that many pro-life groups have set up organizations that claim to support teenage mothers but instead are filled with confrontation.

The influence of religion has also been known to impact the different legal and policy processes including how Uganda chooses to engage with international human rights treaties and processes. It has become customary that religious leaders use the pulpit at any available opportunity to condemn women and girls who have had abortions or seeking abortions as the worst sinners in existence. This practice of moral licensing by the church and religious groups has led to an uptick in stigma, such that even merely seeking to have a discussion about unsafe abortions (which are endemically rampant in Uganda) is cause for panic. This religious lens has also infiltrated the education sector, a classic example being that medical students are taught about "illegal abortions" - a lens that may be attributed to legal licensing by those that develop such curricula. It is worth noting that the medical school curriculum has hardly evolved from the faith-based one rolled out during the colonial era.


In fact, according to Musisi Seggane, control over education and how education was imparted was one of the mainstays of the British Imperial Project. The influence of religion is also seen in the persistence of the concept of conscientious objection that has now become one of the greatest hindrances to provision of abortion care, even in countries like South Africa where abortion access has been liberalized. South Africa's Choice on Termination of Pregnancy Act is a ground-breaking law both regionally and globally and was in part a result of feminist political action.

Nabaneh emphasizes that in order for women to exercise reproductive autonomy and access timely legal abortion services in South Africa, domestic laws must effectively regulate and oversee the practices of the healthcare professions in relation to their implied right to conscientious objection. Failure to effectively regulate and monitor such refusals has created a barrier to women's ability to obtain safe and legal abortion. In Uganda, conscientious objection is mostly done on the basis of religion. The majority of health workers who refuse to provide safe abortion to women refuse because of their faith or with statements of it being morally wrong. This has been seen to be more prevalent in faith-based health facilities which, in some rural areas, are the best suited to offer safe abortion services yet opt not to do so on religious and moral grounds. Not only can institution-wide conscientious objection be challenged on ethical grounds, but the right to conscientious objection can also render illusory any given rights to abortion, as well as the rights to health, life, equality, and dignity that are attendant to abortion.

General Comment No.2 on article 14 (1) (a), (b), (c) and (f) and Article 14(2), (a) and (c) that was adopted by the African Commission in 2014 also addressed states' duty to regulate the practice of conscientious objection in the reproductive health sphere. The existing reservation is that Article 14(2) (c) cannot be construed as serving to restrict international and regional human rights obligations.

The United Nations has unequivocally called upon states not to use religious beliefs to justify women's rights violations. It has recommended that states should repeal gender discriminatory laws grounded in religious beliefs and must address gender-based violence carried out in the name of religion by non-state actors. The special UN Special Rapporteur on Freedom of Religion and Belief also urges states to repeal gender-based discrimination laws, including those enacted with reference to religious considerations that criminalize abortion in all cases, and facilitate practices that violate human rights.

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THE POLITICS OF ABORTION

Feminists recognize that the work of fighting for women's and girls' rights is deeply political. The politics and interests of the day have always dictated how women's and girls' rights, including abortion rights, have been dealt with. There are individual levels of politics, including body politics, sexual pleasure, autonomy, gender identity and sexual orientation that are critical to this discussion and without which we cannot talk about access to safe abortion.

There is also the national and global political realm and how abortion continues to be politicized more than other health issues in this sphere. First, abortion has been used as a political bargaining chip -- as evidenced by presidential election campaigns in the US. The side on which a candidate stands on this issue is a decisive factor for whether or not they end up in the White House. This is not unique to the US; it is not uncommon for Ugandan politicians and other opinion leaders to use stances against abortion to gain political mileage by vilifying persons who seek abortion because they believe those are the views of the wider community, not knowing that abortion is not illegal in Uganda but rather restricted.

In the global sphere, we have seen policies that limit funding for abortion-related services while equally barring recipients of this assistance from taking center stage in the realm of financing for global health issues. The most notorious of these is the Mexico City Policy that is also known as the Global Gag Rule, a policy that was first invoked by President Ronald Reagan and was reinstated by President Donald Trump in 2017. This expanded Mexico City Policy that went further than the previous version has had an effect on a broad range of sexual and reproductive health services, which is of concern especially for low- and middle-income countries like Uganda that are heavily reliant on foreign aid to finance health care. The reinstatement of the Mexico City Policy by Republican presidents is a political requirement to satisfy voters; in fact, these Republican presidents rose to power by weaponizing reproductive and gender issues through the use of tag line statements like "abortion is murder", "homosexuality is a perversion", and "it should be Adam and Eve and not Adam and Steve".

The role of religious fundamentalist groups and their role in backing political allies so that they can advance their conservative ideology has also been a powerful factor in maintaining a conservative stance towards abortion access. It is a well-organized and well-funded global political backlash against gender equality by invoking religious freedom and traditional values and abortion has been placed at its center.

Perhaps, one of the most significant alignments of the far-right agenda and politics is the development and launch of the Geneva Consensus Declaration on Promoting Women's Health and Strengthening the Family. A policy spearheaded by the United States government under President Donald Trump in 2020. It was co-sponsored by five states, including Uganda, and had 33 other signatories. As mentioned in the section on legal and policy frameworks, this declaration is the latest building block for the anti-gender coalition that seeks to invalidate the human right to abortion and defends the rights of states to make their own laws on abortion. This attempt to disregard the well-established norms of international human rights and the entire UN system with the Universal Declaration of Human Rights was a well-orchestrated political move by the Trump administration, aimed to create an alternative human rights system that denies women the right to abortion on the basis of religious and moral grounds.

The manner in which Uganda became a signatory was quite peculiar given that the Ministry of Health is not ordinarily responsible for negotiating and endorsing international agreements on behalf of the Ugandan government, a task that would ordinarily fall under the purview of the Ministry of Foreign Affairs and the Attorney General. Details about whether this international policy document aligns with Uganda's constitution and other legal frameworks were conspicuously missing from the table. It is no wonder that the US has since disavowed this policy, as it is an attack on the rights of women and other members of society.

The Geneva Consensus is not the first attempt by anti-gender groups to subvert the mandate of the UN and advance their conservative ideology, especially on the issue of reproductive health and rights including the right to abortion. The presence of the Holy See (the jurisdiction of the Roman Catholic Pope) is recognized by the Economic and Social Council of the United Nations (ECOSOC) and also holds permanent observer status at the UN, accorded the rights and privileges of participation in the sessions and work of the General Assembly or other organs of the United Nations. Most recently the Holy See was also accorded permanent observer status at the World Health Assembly and has used its presence to influence the outcomes of interstate negotiations on myriad issues including abortion rights and contraceptives, which can be traced back to Pope Paul VI. The Holy See has remained true to its conservative stance in fora like the International Conference on Population and Development, a global consensus that has since 1994 defined key population and development agenda and how the rights of women and girls can be

realized as a central part to development. It is thus notable that the reluctance to the prioritization of interventions to address unsafe abortions in these frame works is in part as a result of political positioning and strategy. Once more, the lives of women and girls are reduced to political bargaining chips and populist interests.

In Uganda's case, the continued maintenance of penal provisions that criminalize abortion on Uganda's law books, together with the failure to operationalize Article 22(2) of the 1995 Constitution of Uganda (never mind that there have been a number of penal code and constitutional reforms and thus numerous opportunities to address the injustices faced by Uganda's women and girls) maybe taken as *prima facie* evidence that there is a lack of political commitment to fulfill the reproductive rights of persons capable of getting pregnant in Uganda. Uganda, like the Holy see, has maintained a conservative stance towards women's abortion rights as evidenced by being the only one of the countries that endorsed the Geneva Consensus. A critical missed opportunity was the placing of a reservation on Article 14 (2) (c) of the Maputo Protocol I at ratification by Uganda in 2010.

This provision calls upon states to take all appropriate measures to "protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother." Even though this reservation does not in any way preclude Uganda from implementing the existing abortion laws in Uganda, it does contribute to the existing perception of total restriction of abortion in Uganda -- more so because Article 14(2)(c) marks a watershed moment as the first time that a human rights treaty explicitly recognized the right to abortion. In making this ratification, the then-Attorney General and Minister of Justice and Constitutional Affairs Hon. Dr. E. Khiddu Makubya, while providing approval for the ratification by Uganda, noted, "according to Ugandan laws, it is irrelevant whether a pregnancy was as a result of sexual assault, rape, or incest. The Penal Code makes it illegal under section 141 and 142 for anyone to assist a person to procure abortion and for anybody to procure her own abortion. In addition to the above, the right to control fertility is an issue for both parties, that is; this man and the woman decide when and how many children they should have. Therefore, this right cannot be left to the women alone since this would defeat the purpose of the protocol."

The reservation that was placed on Article 14 (2) (c) at ratification of the Women's Protocol may be in part attributed to the political interests of the day, where the

rights of women were willing to be recognized but with qualification to fit the values of the society. The disregard for evidence and science about the prevalence of unsafe abortion and the high maternal mortality rates is telling of the key priorities and interests of the state at the time.

The exercise of this political power extends beyond legislation of policies and laws to other facets of the life, including health, education, transport, or finance. The political interests of the day are a key factor when decisions about budget allocation and infrastructure development, including roads (that are required for easy access of health care facilities by women and girls requiring abortion care and other health services) boils down to political considerations.

There is the public sphere of politics, as experienced by women and girls, that is mainly dictated by factors that go on around them -- and there is also the personal sphere including the politics of having to choose, being able to choose, and the circumstances that prevail when a decision is being made. The individual issues and considerations leading up to the decision to terminate a pregnancy are just as critical as the broader environmental factors. Importantly, the ability of the woman, girl or gender-expansive person who has undergone or been faced with the decision to terminate a pregnancy to be able to tell their story as a way normalizing the decision to terminate a pregnancy. The lived experiences of women, girls and gender-expansive persons are critical to understanding the experiences of those who seek safe abortion care and how they access it.

However, these stories are few and far in between. In Uganda, a review of literature revealed a handful of publications that centered the lived experiences of those who had terminated pregnancies or were faced by decisions to do the same.

Feminist theory in the 20th century emerged due to the recognition of the politicization of the everyday lives of women. This struggle continues even today, with the struggle to own the narrative, yet it is glaringly clear that there is an absence of first-hand experiences about abortion. The unavailability of spaces that are safe and non-judgmental for voicing of abortion experiences is telling of the politics of the day, and why silencing these voices is necessary to maintain the state of shame and stigma that is related with abortion.



ECONOMICS OF ABORTION ACCESS

The burden of unsafe abortion falls disproportionately on the poorest women and girls – as a result, every year, some 19 million women have no other choice than to have an unsafe abortion. Many of these women will die as a result; many are permanently injured. Nearly all women who die or are injured are poor and live in poor countries.

As Komusana observed, the anti-abortion laws stem from an assumed patriarchal role to indiscriminately control women's bodies but poor girls and women bear the brunt thereof. Given that many states in Africa including Uganda continue to maintain very restrictive and punitive abortion laws on their books, it is not surprising that a poor woman in many parts of Africa is over 200 times more likely to die as a result of pregnancy and childbirth than a woman in the UK.

A study by the Guttmacher Institute and its partners also found that 62% of women receiving post-abortion care in Uganda were from rural areas and 55% had no access to basic amenities such as a flush toilet, piped water, and electricity. Although half of the respondents said that they had some secondary education, 46% had a primary education or less. The results also showed that while on average women paid about seventeen dollars for post-abortion care treatment, about 30% paid more than this average amount.

Given the economic status of Uganda's women and girls, the high cost of abortion care becomes a relevant consideration for determining whether the services are indeed accessible or not. The International Covenant on Economic and Social Cultural Rights (ICESCR), Article 12, enjoins states to ensure that its citizens attain the right to the highest standard of physical and mental health, and details some actions the state should take to fully realize this right. State performance in this regard can be assessed using the AAAQ framework that forms the basis of the Human Rights Based Approach to Health which has been described as a critical approach to address global health inequalities. One of the "As" is accessibility, and accessibility is physical accessibility and economic accessibility. Economic accessibility requires that health services must be affordable for all. The cost of providing abortion care in the public and private health system should be affordable; one study found that for every dollar spent on contraceptive services, five dollars would be saved on treating complications due to unsafe abortion. The implication of this is that universal access to contraceptive services and safe abortion services are critical to managing public health expenditure on management of complications

from unsafe abortion. And, because the economic burden of unsafe abortion does not end with the cost of hospital treatment but rather carries over to post-hospital care and treatment, the individual and household costs then become a key issue for consideration. Another study indicates that most women reported that their unsafe abortion had had one or more adverse effects, including loss of productivity (73%), negative consequences for their children (60%), and deterioration in economic circumstances (34%).

Women who had spent one or more nights in a facility receiving post-abortion care were more likely to experience these three consequences than those who had not needed an overnight stay. Given the heavy economic impact of managing complications from unsafe abortion at the individual and household level, the affordability question comes into play. Can the women and girls of Uganda afford to experience an unsafe abortion, let alone repeated unsafe abortions, that are not uncommon amongst women and girls of reproductive age?


From a health system perspective, results from 2010 research undertaken by the Guttmacher Institute to fill the knowledge gap about the cost of providing post-abortion care (PAC) on the Ugandan health system found that the average annual PAC cost per client, across five types of abortion complications, was \$131. The total cost of PAC nationally, including direct non-medical costs, was estimated at \$13.9 million per year. Satisfying the demand for PAC would raise the national cost to \$20.8 million per year. The study found that PAC consumes a substantial portion of the total expenditure in reproductive health in Uganda; this is significant and concerning in light of the healthcare sector budget reduction (as was the case in the financial year 2021/2022) against a growing population with increased needs.

Unsafe abortion is both a cause and a result of poverty, thus making economic status a relevant factor for determining whether an abortion service received by a woman or girl in Uganda is safe or unsafe. The safety status of the abortion service has a bearing on the cost, overall experience, and socio-economic outcomes for women and girls in Uganda – not to mention the impact on an already poorly financed public health system.

The impact of the COVID-19 pandemic on physical access to reproductive services cannot be understated. Healthcare facilities and professionals were diverted to the fight against COVID-19, leaving women, girls and minoritized populations

vulnerable, and the mandatory lockdowns left transport and movement the preserve of a few. PAC facilities were hard to reach; as such, many women faced with an unintended pregnancy have either had to carry the pregnancy to term or endure an unsafe abortion. The pandemic and lockdowns revealed the underbelly of existing constraints on the Ugandan healthcare system that limit access to good-quality healthcare as underpinned within the human rights based approach to health care. The situation becomes more dire when the woman or girl is faced with other intersecting socio-economic and/or health issues that make her more vulnerable than others. These factors may include disability, poverty, illiteracy, and age.

For instance, women with disabilities face difficulties accessing sexual and reproductive health services, including safe abortions, due to stigma from health workers. Most healthcare center facilities are unfavourable for women with disabilities. Women and girls with disabilities face expectations that persons living with disabilities should be asexual. Some also receive substandard care, abuse, and humiliation from healthcare workers when faced with procedures, going as far as forced abortion and sterilization. On the other hand, the fight over how and when women should terminate a pregnancy has taken a plot twist, with right wing religious fundamentalist advocates politicizing the issue as a smokescreen for extremist agenda. One of the unfortunate effects of this has been the unholy alliance between conservatives and disability rights advocates; this development is cause for caution, because of the tension related to the exercise of reproductive choice and preventing the birth of children with disabilities. The existence of bio-ethical standards guiding the practice of prenatal genetic testing is hinged on the neutrality of the counselor whose role is to provide information and leave the decision up to the client. As such, even with the attempted politicization of issue of abortion on the grounds of fetal abnormality, the bodily autonomy of the person experiencing the pregnancy is paramount and cannot be subjugated to that of the fetus. Economic inequality has indeed conspired with patriarchal structures that sculpt and reinforce gendered power imbalances and traditional gender norms, thereby compromising women's decision-making power and access to the necessary tools required to facilitate implementation of the decisions related to these choices.



THE ROLE OF THE ANTI-GENDER MOVEMENT

A feminist approach to abortion requires that feminists and allies are alive to the operations of anti-gender far right religious fundamentalist groups. These groups have made it their core business to oppose women's reproductive rights and gender justice by advancing a patriarchal, gender-restrictive world view.

Anti-gender groups are firmly convinced that their beliefs are true and, as a result, endeavor to reassert—through various political mechanisms—a union between the state and religion as a way to impose their discourse on life and reproduction (which stands in strong opposition to sexual and reproductive rights) and demand that it become the official discourse of the state. This state of affairs has been quite prevalent in Uganda and the struggle for realization of abortion rights is at the center of this.

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The strategies employed by these groups on a global level include conferences, one of the most notorious being the World Congress of Families that has since 1997 been convening around the globe in an attempt to spread hate, intolerance, and homophobia under the guise of protecting the “natural family” as the only fundamental and sustainable unit. The group is active on 5 continents in the world. Others include Sharon Slater's Family Watch International that is very active across Africa promoting policies and programs to ostensibly ‘strengthen the family and to protect the best interests of children’. CitizenGo International and its Kenya-based Africa chapter have been at the center of opposing gender equality and sexual reproductive health programs and any policy and legal enactments aimed at enhancing the same. They do this through the use of petitions targeting duty-bearers

like parliaments, presidents, and others. They are currently very actively challenging the process of enacting the East Africa Community Sexual Reproductive Health Bill 2021 through the use of their online petition platform. They claim that the bill will promote abortion and sexualization of children, a scare tactic that they have employed many times before on the continent. These groups work both separately and in tandem to renew and expand colonial-era proscriptions on abortion rights. They have a far reach and open smaller organizations/offices and charities in Uganda and churches. They prey on the traditional, imperialist, super-religious culture of Ugandans by hypocritically convincing leaders that Western attempts to legalize abortion equal meddling. The anti-gender footprint has never been more institutionalized than it was in 2018 when the Uganda Pro-Life Parliamentary Caucus was launched by the then-Speaker of Parliament who also doubled as its patron.

The Caucus, comprising legislators from all religious denominations and backgrounds, described itself as an advocacy group campaigning against abortion and aimed at protecting the family and life from disguised human rights that threaten life and God's purpose.

The role of the anti-gender far-right religious fundamentalist groups cannot be understated given that some of the members of these groups are leaders in Ugandan political office, as expounded above. Their use of religion as a basis for decision-making is dangerous and promotes a view of a heteronormative, marriage-normative, submissive model of womanhood and the homogeneity of humans, a stance that fuels the exclusion and discrimination of minorities and groups that are often living at the margins of society. They influence not only politics but public opinion too. Irrespective of the socioeconomic and public health impacts of their activities, these anti-gender groups continue to push for the outlawing of abortions or the maintenance of rigid abortion laws in many African countries, Uganda inclusive. It is not uncommon for them to use terms like “un-African” or “un-Christian” when it comes to the topics of abortion.

The phenomenon of pregnancy crisis centers (that purport to provide “compassionate, Christ-centered care” to persons facing unplanned pregnancies) is well-established in the US, and has been exported to Africa. Uganda is no exception. In an undercover investigation conducted by Open Democracy, these crisis pregnancy centers were found to use a combination of tactics including blaming

clients, the majority of whom are young women, and accusing survivors of sexual assault or incestuous relationships and of having “consented in a way”. They brand themselves as safe havens for young women and girls faced with a “crisis pregnancy” while utilizing stalling tactics, blackmail, shaming, and pseudo-science to talk their clients out of having abortions or delaying the decision so that ultimately the option is off the table altogether. These facilities masquerade as shelters but as soon as the baby is delivered, they turn these young women out in the world to fend for themselves; some are even turned out before delivery but after it is too late to terminate the pregnancy. This exploitation of the social and economic vulnerability of young women and girls seeking care is cruel, inhuman, and is in violation of the prescribed standard operating procedures that the Ministry of Health has established to guide the delivery of reproductive health services in Uganda. What is surprising is that some of these self-proclaimed crisis pregnancy centers are actively collaborating with the Ministry of Health. The question then becomes, are these registered health facilities that are operating within the relevant legal and policy regime in Uganda?



THE DILEMMA OF CONSCIENTIOUS OBJECTION

In addition to the impact of laws and policies, the issue of conscientious objection also impacts women's abortion access experiences within the health care system. Freedom of conscience is also guaranteed under Uganda's constitution, under the same provision that protects freedom of religion, and these two together have become an acceptable premise for refusal by a health care provider to provide abortion care.

Data on the prevalence of conscientious objection is scarce and problematic given that most of this is not embedded in statutes/laws but is assumed by the health workers. It is unregulated and gives health workers leeway to avoid providing the service. In Zambia, for example, a health worker is not required to record their objection to abortion services; this renders it difficult to manage women seeking abortions, given that many of them are repeatedly referred back to the same objecting health worker thereby delaying their access to care.

In Sub-Saharan Africa, based on a cross-sectional census conducted at hospitals in northern Ghana, reported prevalence of self-identified conscientious objection among physicians, midwives, nurses, and physician assistants was at almost 40%. More than 25% of midwives attending a conference in Ethiopia in 2015 indicated they would not provide abortion services, and an ethnographic study of Senegalese obstetrician-gynecologists, midwives, and nurses found very few providers were willing to provide the abortion services that they believed should be readily available. It is noted that the secrecy with which abortion is provided is the same secrecy with which a conscientious objection is made.

In South Africa it has been found that conscientious objection is not invoked when extra financial remuneration is given or when the abortion seeker is a friend or family member. This shows that conscientious objection is often used by some health workers to extort women seeking abortion services. Most of these health workers do not exercise their objection correctly by giving reasons based on their religion and culture: most object by stating that the reasons a woman is seeking an abortion are not sufficient to warrant one.

The exercise of conscientious objection becomes pertinent to feminists' efforts towards ensuring abortion access because it is often difficult to distinguish between the personal convictions of a health service provider based on religion and those based on political position, both of which are structures that have conspired to ensure that women remain oppressed and marginalized members of society.

Religion plays a role in denying women access to safe abortion and influences attitudes of health providers towards abortion. In circumstances where a health facility or the employer of a health worker is religiously affiliated, they rarely provide post-abortion care, disregarding the fact that post-abortion care is not restricted under law or policy in Uganda. They are more inclined to detach themselves from the woman's plight or refer her to another facility.

Scholars have argued, rightly so, that the exercise of conscientious objection jeopardizes women's health and human rights as it unfairly privileges the doctor's conscience over their patients' needs. Conscientious objection weakens the full realization of reproductive rights and women's equality. It is no wonder that the Maputo Protocol General Comment 2 on Article 14 recognizes that where conscientious objection is raised then state parties should ensure that there are proper referral mechanisms that allow women to receive timely care, and that only health workers can object but not entire institutions. It further states that the objection cannot be raised when a woman's life is at risk. Many health workers in Uganda that have the skill to provide medical abortions choose not to do so. In communities where health facilities are few, like in the case of Uganda, a woman finds it very difficult to find a non-objecting gynecologist and thus access a safe abortion. Challenging restrictive laws that make abortion inaccessible to women should be coupled with regulation of the practice of conscientious objection since it has the potential to nullify the gains made via legal and policy reform as has been observed in jurisdictions like South Africa.

RECOMMENDATIONS

- ✿ A legal and policy overhaul to facilitate abortion access needs to be prioritized. This may include, but is not limited to, repealing Sections 141, 142, and 143 of the Penal Code Act; operationalization of Article 22(2) of the 1995 constitution of Uganda; and the reinstatement of the Standards and Guidelines for Reduction of Maternal Mortality due to Unsafe Abortion in Uganda (2015). The existing legal regime on abortion interferes with “human dignity,” which “requires that individuals are free to make personal decisions without interference from the state, especially in an area as important and intimate as sexual and reproductive health”.
- ✿ Taking inspiration from other feminist movements that have been able to create abortion law reforms within their countries, as exemplified by the passage of South Africa’s Choice of Termination of Pregnancy (CTOP) Act that was partly a result of feminist political action. Lessons from countries like Rwanda that managed to reform its abortion laws, including lifting the reservation on Article 14(2)(c) of the Maputo Protocol. Rwanda amended its Penal Code in 2018 to permit abortion in cases of rape, incest, forced marriage, or if the pregnancy threatens the health of the woman. Through a Ministerial Order, the regulation of abortion through the requirement for court approval and a second doctor’s permission were removed. Despite the fact that Rwanda is a socially conservative state, the public health realities of the high mortality and morbidity resulting from unsafe abortion and the lived realities of women and girls were key considerations by the state in arriving at this decision.
- ✿ The personal is political, and the personal stories of women and their abortion experiences need to be centered in the agitation for abortion law reform in Uganda. An examination of states that have made progress to amend their abortion laws will reveal that among the strategies used, the centering of the lived experiences of women and girls in the quest for abortion access is inextricable from the process if success must follow. In Rwanda, the testimonies of young people played a role in mobilizing for law reform. In Ireland, Savita Halappanavar’s death spurred Ireland’s abortion rights campaign. The story of the death of Savita came to be synonymous with calls for the repeal of Ireland’s Eighth Amendment, which effectively banned abortion in Ireland. Her story galvanized the campaigners calling for an end to the ban and was cited again and again when the country overwhelmingly voted to repeal the amendment. Much closer to home, and maybe even more relatable, is the

decision in the JMM case by the High Court of Kenya that took cognizance of the agony suffered by JMM and her mother. JMM, a 14-year-old girl, had an unsafe abortion at the hands of a quack and ended up at Kisii Level 5 Hospital but her life was not saved because there was no qualified health service provider to provide post-abortion care. This case was brought up to challenge the withdrawal of the 2012 Standards and Guidelines and the Training Curriculum by the Ministry of Health of Kenya. The arbitrary withdrawal of the guidelines was deemed to be in violation of the rights to fair administrative action under Article 47; to non-discrimination under Article 27; to dignity under article 28; to information under Article 35; and, most importantly as in the case of JMM, the right to life. The successful judgment in this case is attributable to JMM's story giving a face to the real impact of an unclear regulatory framework on abortion in Kenya.

✿ Women, girls and gender-expansive persons are diverse and their health needs are varying yet interconnected. There is therefore need for an intersectional movement advocating of the rights of women, girls and gender-expansive persons including abortion rights. This intersectional movement should take cognizance of women's health and rights, economic empowerment, access to justice among others. Persons with disabilities have for the longest time been "othered" in the discussion around abortion rights – a situation that has led to opportunistic alliance between the disability movement and far-rights radical groups, as discussed earlier. The unique needs of all women and their lived realities should be centered so that programs for abortion service delivery are relevant to their lived experiences. Where abortion law reform has happened, it is because various movements formed alliances to deliver a formidable campaign. Uganda's feminist movement, reproductive health movement, youth movement, LGBTIQ+ movements, sex worker groups, cyber and digital security actors and more must join hands to deliver abortion rights for all who need them in Uganda.

✿ The lived realities of women in Uganda remain risky due to the persistently high number of deaths from unsafe abortions every year, and the rising costs on the state in treating complications of unsafe abortions which burden the already underfunded health sector. The role of feminists and allies in advancing abortion rights in Uganda cannot be overemphasized, and the quest for bodily autonomy and the ability of women, girls and gender-expansive persons to

assert their agency is critical to the realization of gender and reproductive justice. Feminist organizations should seek to intersect and infuse feminist theory and practice into the mainstream reproductive rights movement if headway is to be made on abortion access. The protagonists against reproductive justice and gender justice, be they individuals, organizations, movements, or systems, are the same and are mutually re-enforcing.



The anti-gender movement is one of the greatest challenges that feminist organizing faces at the moment – be it pushing back against women’s rights to non-discrimination and equality, seeking to curtail reproductive choice and autonomy including the right to abortion and contraceptives, or even the use of disinformation and cyber harassment to silence and bully women from exercising their voice and agency in the public sphere. These are well-funded, politically connected, and well-coordinated actors. They have made their way into Uganda as evidenced by the establishment of the Pro-Life Parliamentary Caucus in 2018, aimed at campaigning against abortion by using legislators to agitate. This is evidence that anti-gender actors are very present and working at the highest political levels in Uganda. The women’s movement and champions of women’s rights need to make efforts to track, monitor their actions, and put in place pre-emptive strategies to mitigate their attacks against realization of abortion care in Uganda.

CONCLUSION

There is no doubt that safe abortion access, like other gender justice issues that feminists are working to defend, is hampered by multi-faceted systems of oppression and exploitation that mutually support each other. Culture, religion, and law have been weaponized to limit access to abortion services for women. The power patriarchy and in turn men wield in Ugandan society has been used to ensure that they have the final say when it comes to issues of reproduction, including when and how often to have children. By influencing laws and policies and withholding funding for organizations that are service providers of abortion drugs, external forces have used not only religion but financial sway to ensure that women, girls and gender-expansive persons do not access timely abortion care; restrictive religion-based laws that subjugate women, girls and gender-expansive persons in their diversities have also been used to ensure that doors remain closed to those seeking abortion services.

We live in a world where there has always been inequality in every aspect of life between genders, the act of sex and reproduction being no exception. The quest for sex on equal terms without consequences such as unwanted pregnancies should be, and is, a radical act of self-care and self-preservation.

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