

THE STATE OF SEXUAL REPRODUCTIVE HEALTH AND RIGHTS IN UGANDA

EMERGING ISSUES

Submission to the universal periodic review of Uganda

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KEY WORDS: Sexual reproductive health and Rights; Health; Adolescent health; discrimination; Gender based violence; contraceptive information; unsafe abortion.

I. EXECUTIVE SUMMARY

1. In accordance with Human Rights Council Resolution 5/1 of June 18, 2007, this is a report jointly submitted by civil society organizations working in the area of Sexual reproductive Health and Rights (SRHRs) in Uganda. The compiling of the report has been spearheaded by the **Center for Health, Human Rights and Development (CEHURD)**¹, a not for profit research and advocacy organization founded in 2007 and registered under the laws of Uganda. It works to ensure that laws and policies are used as principal tools for the promotion and protection of health and human rights of populations in Uganda and in the East African region.
2. Founded in 2007 and fully registered under the laws of Uganda, CEHURD focuses its efforts on critical issues of human rights and health systems in East Africa such as sexual and reproductive health rights, trade and health, and medical ethics which affect the vulnerable and less-advantaged populations such as women, children, orphans, sexual minorities, people living with HIV/AIDS, persons with disabilities, among others.
3. The Government of Uganda (GOU) has committed over the years to the reduction of maternal mortality and improving sexual, reproductive health and family planning services through adopting international and regional instruments² and standards like the Sustainable Development Goals (SDGs), and a number of policies and strategies at the national level which include; Uganda Vision 2040, The national development plan (2009/10-2014/15), Health Sector Strategic Plan (2010/11-2014/15), National health policy, the gender policy, National policy guidelines and service standards on sexual reproductive health and rights (2012), the adolescent health policy, health strategic plans among others.
4. Despite these commitments, Women and girls in Uganda continue to face difficulties in accessing SRH services. This submission therefore highlights the following issues of concern: (A) **Maternal and Reproductive Health care services and commodities**; Uganda's maternal mortality rate in 2014 was at 360 deaths for every live birth and risk of a mother dying while giving birth in a health facility was estimated at 118 deaths for every live birth in the financial year 2014/2015 (Ministry of Health, 2015) yet accessing quality reproductive health care services from government health facilities is a hurdle: (B) **Sexual and Gender based Violence against women and girls**; 60% of married women have experienced some form of violence and these are perpetuated by cultural and societal views in the existing patriarchal society: and (C) **Discrimination and stigma against Women Living with HIV and AIDS**, women are mostly affected by the upsurge in HIV prevalence in Uganda and are more prone to stigma and discrimination than men. The HIV/AIDS prevention and Control Act 2014 exacerbates this situation with the contentious clauses including forced disclosure, mandatory HIV testing and intentional passing on of HIV

II. KEY ISSUES

A) Maternal and reproductive health care services and commodities.

i. Access to maternal healthcare services

5. According to the Uganda Demographic Health Survey 2011, maternal mortality is the leading cause of death among women of childbearing age in Uganda with over 80% of all maternal deaths being as a result of: severe bleeding (mostly bleeding after childbirth), infections (usually after childbirth), high blood pressure during pregnancy (pre-eclampsia and eclampsia) and unsafe abortion among others.
6. During the previous Universal Periodic Review (UPR) of Uganda, the government accepted recommendations to continue to work towards reducing the high maternal mortality rates and increase access to SRH services by raising the health budget to 15%.³ The Committee on Economic, Social and Cultural Rights (CESCR Committee), during its review of Uganda in 2015, also expressed concern regarding the high rate of maternal mortality, and recommended the state to intensify its efforts to reduce the rate including by sufficiently equipping facilities to provide antenatal, delivery and postnatal care.⁴ Despite these recommendations, however, the maternal mortality remains relatively high due to the low budget allocation to the Health sector and an almost impossible free access to the available services.
7. **Recommendation:** The government needs to intensify its efforts of making maternal health care services more accessible including by allocating adequate resources.
8. **Recommendation:** The government needs to increase budget allocation to the health sector by allocating 15% of the national budget to the sector as committed in the Abuja declaration

ii. Affordability of health care services.

9. Despite the government abolishing cost sharing in the public sector in Uganda, it has yet to be universally implemented or enforced by the government. The current situation as it stands exacerbates the vulnerability of those who cannot afford health care services. It also provides avenues for corruption for health care employees. Out of pocket expenditure in the health sector contributes to up to 70% ranging from informal “under the-table” payments to health workers to buying prescribed medication from private health facilities, a feature of many nominally free health services. This practice has not only denied Ugandans access to health care services but has also resulted into death of patients.
10. Constitutional petition No. 16 of 2011 for example, a case challenging death of expectant mothers in public health facilities cites two cases of ladies, one of whom died at Mityana

Hospital for failure to pay for three bottles of rehydrating water, and airtime to call the health service provider on duty⁵

11. **Recommendation:** The government needs to revisit its no cost sharing policy since it has impacted on access to health care services within public facilities.

iii. **Adolescents access to quality sexual and reproductive health services**

12. Although the government is to be commended for establishing policies to address adolescent access to sexual and reproductive health services, including the Adolescent Health Policy Guidelines and Service Standards⁶ and the National Minimum Healthcare Package,⁷ implementation of these policies is yet to be realized.
13. Bridging the gap between service delivery and implementation of the policies is important given that nearly 1 in 4 Ugandan girls aged 15-19 have already given birth or is pregnant with her first child⁸ and 14% of young women have their first sexual encounter before the age of 15. Inadequate access to sexual and reproductive health services results in affiliated rise in maternal morbidity and mortality,⁹ higher HIV/AIDS rates amongst adolescents and greater drop-out rates among school-aged girls.¹⁰
14. **Recommendation:** Government should ensure adolescent's access to reproductive health by coming up with a clear plan and budget line on implementation of the adolescent health policies.
15. **Recommendation:** Government should invest at least 5% of its annual Health sector budget to adolescents' access to quality reproductive health services.

iv. **Inadequate access to contraceptive information and services**

16. Uganda's legal framework allows access to information for as long as it doesn't prejudice the security of the state. Accessing health related information is however problematic yet access to family planning information and services is vital in protecting women's' and girls' rights to life and health. Inadequate access to such information and services may lead to women and girls experiencing unwanted pregnancies, possibly resulting in death or illness due to lack of adequate healthcare, or they may seek out unsafe abortions that result in injury or death.
17. Although the state has made efforts to improve access to family planning information and services, the unmet need for family planning for women in Uganda stood at 34%¹¹. In addition, while the use of modern contraception increased from 15% in 2007 to 26% in 2011, majority of women and girls still do not have access to contraceptive information and services¹². Further, the use of, and access to, contraception among women also varies depending on geographical location, level of education and income level. The 2011

UDHS further notes that 46% of married women living in urban areas used some method of contraception, as opposed to only 27% of married women located in rural areas. In addition, 44% of married women with a secondary level or more of education used contraceptives as compared to only 18% of those with no education.

18. This low rate is attributed to a number of barriers women and girls face including associated user fees for the services, unavailability of a preferred contraceptive method, and improper counseling services. Other factors, such as the fear of side effects, the inconvenience of using modern contraceptives, partners' opposition to contraceptive use and the belief that contraceptives are prohibited by religion, inhibit women from using contraceptives. Further men's misconceptions regarding contraceptives, such as that they cause health problems, influence women's use of the methods are also attributed to low rate.
19. **Recommendation:** The government should ensure universal access to family planning information and services.
20. **Recommendation:** The government should invest in a country wide sensitization program on reproductive information.

v. Lack of an enabling legal environment for access to safe abortion services.

21. Uganda's legal framework lacks clarity with regard to provision of abortion services. The constitution (Article 22 (2)) allows for termination of pregnancy as prescribed under the law. The authorizing legislation, the Penal Code Act both gives authorization and restriction on provision of abortion care. As a result, medical practitioners are often arrested by police and charged under the Penal Code Act for procuring an abortion even when they are providing post abortion care especially if a woman has presented with complications from an unsafe abortion. This makes it difficult for a medical practitioner who is constitutionally allowed to practice profession to provide abortion treatment due to fear of being arrested. This criminalization has also perpetuated gender stereotypes, marginalized and disempowered women by forcing them to make difficult decisions about their health and well-being or facing criminal liability, which makes them opt for clandestine methods often leading to death.
22. In June 2015, the Ministry of Health issued the "Standards and Guidelines for the Reduction of Maternal Morbidity and Mortality from Unsafe Abortion in Uganda," (S&Gs) with the aim of strengthening mechanisms to address unsafe abortion which include reducing the number of unwanted pregnancies through sensitization and health talks; increasing access to family planning; and as a secondary prevention, increase access to Comprehensive Abortion Care (CAC) services." If implemented effectively the S&Gs are expected to improve the quality of medical care services by providing clear guidance on the provision of safe abortion services and the management of unsafe abortion as well as educating health workers and policy makers.
23. Human rights bodies have found that both restrictive abortion laws and the failure to ensure access to abortion when it is legal are incompatible with international human rights obligations, amounting to violations of the rights to life and health, the right to be free from cruel, inhuman and degrading treatment, and the right to be free from

discrimination. Particularly Uganda has ratified the African Charter on Human and people's rights on the rights of Women in Africa (Maputo Protocol) with a reservation to article 14(2) (c) which requires states to authorize medical abortion in cases of rape, incest and where the pregnancy threatens the life or health of the women or the fetus. This reservation greatly impacts on women's rights to access safe abortion services.

24. In addition to international and regional obligations, Uganda's reproductive health guidelines list, provides for PAC as a component of maternal and newborn health services that should be provided to women who have had an abortion. However, evidence shows that most health care facilities in Uganda are poorly equipped to manage PAC. Supplies that are crucial to the provision of PAC are only available in small percentage within a few health facilities that offer delivery services. A study published in 2014 revealed that Manual Vacuum Aspiration (MVA)—the preferred method for PAC for first trimester abortions—was not available in all health care facilities and providers were no trained to use the equipment. In addition, due to the misconception about the legality of abortion, doctors may also refuse to perform PAC for fear of being reported to the police.
25. **Recommendation:** Government should operationalize Article 22 (2) of the Constitution to ensure access to safe and legal abortion services to women and girls.
26. **Recommendation:** The state should remove all legislative barriers that prohibit young people especially unmarried young women from accessing sexual and reproductive health services and family planning.
27. **Recommendation:** The state should come up with concrete plans for training health service providers and implementing the Standards and Guidelines for the Reduction of Maternal Morbidity and Mortality from Unsafe Abortion in Uganda

VI. Impediment on access to sexual reproductive health services by LGBTI persons.

28. While Uganda in general may face challenges arising from poor health system, sexual minorities are disproportionately affected because they have to contend with these general challenges as well as with those specific to them as lesbians, gay, bisexuals, trans gender and intersex (LGBTI) people. These challenges range from legal, social and economic factors in enjoyment of their SRHR. The existence or archaic laws that criminalize “carnal knowledge” against the order of nature have impeded access to SRHRs services by LGBTI as such provisions are used against LGBTI persons in the health sector.
29. Further, almost all health policies in Uganda apart from the National AIDS strategic plan 2015-2020 do not recognize the health needs of LGBTI persons. UNAIDS in its THE GAP report, notes that LGBT persons are both left behind and most at risk populations. The HIV prevention rate of Men who have sex with Men (MSMs) stands at 13.7% which is way above the National IC prevention rate which stands at 7.3% . The exclusion of this population from health policies has thus greatly impacted their access to SRH

services including access to HIV treatment and counseling. Although the Government is commended for setting up a Most at Risk Population initiative (MARPI) clinic to provide HIV services to these populations, these clinics are however few and overstretched with no capacity to reach out to all LGBTI persons in the country.

30. Recommendation: The state should also review health policies to include specific programs targeting all LGBTI persons and increase avenues with LGBTI health friendly health services.

31. Recommendation: Government should set up more MARPI clinics to provide SRHR services to most at risk populations including LGBTI persons

VII. Limited Access to Sexual and Reproductive Health Services by Refugees in Uganda

32. Uganda is experiencing an influx of over half a million people fleeing violence and human rights abuse from countries such as; South Sudan, Burundi and the Democratic Republic of Congo, among others. Majority of refugees are women, out of which 70% are estimated to be of reproductive age. There is limited access to basic emergency-obstetric services for these refugee women, only a small proportion of deliveries are attended by skilled service providers, sexual and gender based violence is on a rise, and transmission of sexually transmitted infections, including HIV. Unfortunately, the local health facilities are not able to keep up to the increasing demand, hence increasing a desperate need for sexual and reproductive health services¹³.

33. Sexual and reproductive health is a key aspect of healthcare provision that does not disappear in humanitarian situations, but instead the demand for resources and services only increases. It is therefore crucial that the government of Uganda plans to incorporate and promote sexual and reproductive health service delivery within its emergency planning in order to meet the growing need. If neglected in humanitarian situations, there are likely consequences for the men, women, children and the country at large

34. Recommendation: The Government should prioritize the provision of sexual and reproductive health services for the refugees by deliberately incorporating and promoting it within its emergency plans and policies, and by effectively implementing the plans and policies in order to meet the demand.

B) Sexual and Gender based Violence against women and girls

35. Uganda has a strong legislative and policy framework that supports women's empowerment and equality although its society is characterized by strong patriarchal beliefs that value male supremacy and women's subordination. According to the UDHS 2011, about 60% of ever-married women have experienced some form of violence (physical, sexual, emotional) by a husband or intimate partner. Cultural and societal views perpetuate violence against women, with 58% of women believing that physical violence against women is justifiable in at least certain circumstances.
36. Uganda accepted a number of recommendations with respect to sexual and physical violence against women and girls during the 2011 UPR, which called upon it to implement the Domestic Violence Act of 2010, which was intended to, among other things, "provide for the protection and relief of victims of domestic violence." Other Human rights committees for example CESCR Committee, in 2015 expressed concern regarding the "inadequate implementation of the Domestic Violence Act, and the delays in adopting the Sexual Offences Bill.
37. However, marital rape is not expressly prohibited by the Domestic Violence Act yet the implementation of the Act itself is still slow. Due to the government's failure to effectively implement legal and policy measures therefore, violence against women and girls remains alarmingly high. Even when victims report sexual violence, women face difficulties to relief and justice.
38. **Recommendation:** The government should fast track the implementation of the Domestic Violence Act.

C) Discrimination and Stigma against Women Living with HIV and AIDS

39. Studies estimated that over 1.5 million Ugandans were living with HIV/AIDS in 2014, representing 7.3% of the total adult population¹⁴, a marked increase since 2005. During the previous UPR, Uganda accepted recommendations aimed at advancing quality health care for all and ensuring a prevention of HIV/AIDS preference.
40. Despite that, the president assented to a contentious HIV and AIDS Prevention and Control Act with an aim of "preventing and controlling HIV". The Act which contains several contentious provisions will increase stigmatization and discrimination, which will consequently hinder the public health response to a recent increase in the HIV prevalence rate in Uganda. These clauses include mandatory testing (section 13), criminalization of transmission of HIV (section 41 and 43) and disclosure without consent (section 18).
41. **Recommendation:** The HIV/AIDS Prevention and Control Act should be called back to Parliament and clauses relating to criminalization of transmission of HIV, disclosure without consent, and mandatory testing removed or amended.

¹ www.cehurd.org

²International Covenant on Economic social and Cultural rights, African Charter on Human and People's rights, African Charter on Human and people's rights on the rights of women in Africa.

³ Human Rights Council (HRC), Rep. of the Working Group on the Universal Periodic Review: Uganda, ¶¶ 111.86, 111.90, 111.91, U.N. Doc. A/HRC/19/16 (Dec. 22, 2011), available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G11/175/48/PDF/G1117548.pdf?OpenElement>

⁴ Committee on Economic, Social and Cultural Rights (CESCR Committee), *CESCR Committee considers report of Uganda*, available at <http://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=16069&LangID=E> (accessed Feb. 16, 2016).

⁵ <http://www.cehurd.org/publications/?did=13>

⁶Ministry of Health. Adolescent Health Policy Guidelines and Services Standards. In: Kampala Uganda: The Reproductive Health Division. 3rd ed. Uganda: Department of Community Health, Ministry of Health; 2012.

⁷Ministry of Health; Uganda. Uganda National Health Policy. Kampala: Ministry of Health; 1999.

⁸ UBOS and ICF International: Uganda Demographic and Health Survey 2011. In. Kampala, Uganda and Calverton, Maryland: Uganda Bureau of Statistics (UBOS) and ICF International Inc.; 2012.

⁹Rutarema Gideon. Factors Associated with Adolescent Pregnancy and Fertility in Uganda: Analysis of the 2011 Demographic and Health Survey Data, Social Sciences. Vol. 2, No. 1, 2013, pp. 7-13. doi: 10.11648/j.ss.20130201.12

¹⁰Rutarema Gideon. Factors Associated with Adolescent Pregnancy and Fertility in Uganda: Analysis of the 2011 Demographic and Health Survey Data, Social Sciences. Vol. 2, No. 1, 2013, pp. 7-13. doi: 10.11648/j.ss.20130201.12

¹¹ Uganda Demographic and Health survey, 2011

¹² ibid

¹³ <http://www.ippf-sprint.org/ippf-sprint-initiative-to-provide-humanitarian-assistance-to-the-burundi-refugees-in-uganda/>

¹⁴ UNAIDS, "Uganda: HIV and AIDS estimates (2014)," available at <http://www.unaids.org/en/regionscountries/countries/uganda>.