

SHADOW LETTER

REPRODUCTIVE RIGHTS IN UGANDA: A SHADOW LETTER AND SUMMARY OF CONCLUDING OBSERVATIONS



CENTER
FOR
REPRODUCTIVE
RIGHTS

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CENTER
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MISSION AND VISION

The Center's Mission and Vision

The Center for Reproductive Rights uses the law to advance reproductive freedom as a fundamental human right that all governments are legally obligated to protect, respect, and fulfill.

Reproductive freedom lies at the heart of the promise of human dignity, self-determination, and equality embodied in both the U.S. Constitution and the Universal Declaration of Human Rights. The Center works toward the time when that promise is enshrined in law in the United States and throughout the world. We envision a world where every woman is free to decide whether and when to have children; where every woman has access to the best reproductive healthcare available; where every woman can exercise her choices without coercion or discrimination. More simply put, we envision a world where every woman participates with full dignity as an equal member of society.

FIDA-Uganda's Mission and Vision

To promote the human rights and the inherent dignity of women and children using law as a tool of social justice.

FOREWORD

In October 2010, the Committee on the Elimination of Discrimination against Women (CEDAW Committee), charged with monitoring states' compliance with the Convention on the Elimination of All forms of Discrimination against Women (CEDAW Convention) reviewed Uganda's combined 4th, 5th, 6th and 7th periodic reports. This review conformed with Uganda's obligations under the Convention, which it ratified in 1985.

Prior to this, Uganda last submitted a report to the Committee in 2002. It was, consequently, a rare opportunity for non-governmental organizations (NGOs) and other key stakeholders to submit alternative reports on the status of Uganda's compliance with the Convention. The Center for Reproductive Rights (the Center) and the Uganda Association of Women Lawyers (FIDA-Uganda) submitted a shadow report, which focused on the status of reproductive health and rights in Uganda. Both organizations engaged in extensive advocacy before the Committee during informal meetings with NGOs at the reporting session which was held in Geneva, Switzerland.

This publication highlights key issues affecting the reproductive health and rights of women in Uganda and provides a concise analysis of the concluding observations to underscore the obligations that they impose on the government of Uganda. The recent concluding observations of the African Commission on Human and Peoples' Rights, regarding Uganda's compliance with the African Charter on Human and Peoples' Rights and Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, are also discussed to emphasize the obligations the government owes at both the regional and international levels to protect the reproductive health and rights of women in Uganda.

FIDA-Uganda and the Center anticipate that the information provided in this publication will inform the advocacy strategies of key stakeholders and strengthen their capacity to hold the government of Uganda accountable for fulfilling the recommendations issued by these mechanisms before its next reporting session.

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SHADOW LETTER

THE RIGHT TO REPRODUCTIVE HEALTH SERVICES AND INFORMATION [ARTICLES 10, 12, 14(2)(B) AND 16(1)(E)]

Ratification of the Convention commits states to ensure “[a]ccess to specific educational information to help ensure the health and well-being of families, including information and advice on family planning” [Article 10(h)]; “to ensure, on a basis of equality of men and women, access to health-care services, including those related to family planning [and] to ensure [...] appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary” [Article 12]; to “take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure... access to adequate health care facilities, including information, counseling, and services in family planning” [(Article 14(2)(b)); and to ensure to women the “rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights” [Article 16(1)(e)].

September 20, 2010

**The Committee on the Elimination for Discrimination against Women
(CEDAW Committee)**

Re: Supplementary Information on Uganda

Dear Committee Members:

This letter is intended to supplement the combined 4th, 5th, 6th and 7th periodic reports of the Government of Uganda, scheduled for review by this Committee during its 47th session. The Center for Reproductive Rights (the Center), an independent nongovernmental organization that uses the law to advance reproductive freedom as a fundamental human right, and the Uganda Association of Women Lawyers (FIDA-Uganda), an independent nongovernmental organization that protects and promotes the human rights and inherent dignity of women and children using law as a tool for social justice, hope to further the work of the Committee by reporting information concerning the rights protected in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW or “the Convention”).

This letter highlights areas of concern related to violations of women’s and girls’ reproductive and sexual health and rights in Uganda. Despite explicit protections in the Convention, these rights continue to be neglected and, at times, blatantly violated. We wish to bring the Committee’s attention specific areas of concern, including women’s lack of access to quality maternal healthcare, to family planning services and information, and to HIV services; lack of access to safe abortion and post-abortion care services; and discrimination and sexual violence against women, adolescents and schoolgirls.

I. THE RIGHT TO REPRODUCTIVE HEALTH SERVICES AND INFORMATION [ARTICLES 10, 12, 14(2)(B) AND 16(1)(E)]

Reproductive rights are a fundamental basis for equality in health and society and a crucial part of the Committee’s mandate under CEDAW.¹ Ratification of the Convention commits states to ensure “[a]ccess to specific educational information to help ensure the health and well-being of families, including information and advice on family planning” [Article 10(h)]; “to ensure, on a basis of equality of men and women, access to health-care services, including those related to family planning [and] to ensure [...] appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary” [Article 12]; to “take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure... access to adequate health care facilities,

including information, counseling, and services in family planning” [(Article 14(2)(b)); and to ensure to women the “rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights” [Article 16(1)(e)].

A. Maternal Mortality and Morbidity

The CEDAW Committee has recognized that high maternal mortality² and morbidity³ rates may signify violations of women’s right to life and “provide an indication ... of possible breaches of [state] duties to ensure women’s access to health care.”⁴ Further, the Committee has stated “that it is the duty of States parties to ensure women’s right to safe motherhood and emergency obstetric services and they should allocate to these services the maximum extent of available resources.”⁵

State of Maternal Health in Uganda

The maternal mortality ratio in Uganda is 550 maternal deaths per 100,000 live births, according to statistical data from the UNICEF and the World Health Organization.⁶ This figure is higher than the one provided in the Ugandan Government’s report and adjusts for the possible underreporting of maternal deaths in the 2006 Demographic and Health Survey for Uganda (2006 UDHS).⁷ Under the Millennium Development Goals, Uganda has committed to reducing its maternal mortality rate to 132 deaths per 100,000 live births by 2015.⁸ Given the current state of maternal health services in Uganda, it appears highly unlikely that the government will meet this commitment.

For every maternal death in Uganda, six women suffer severe morbidities—such as anemia, infertility, pelvic pain, incontinence and obstetric fistula⁹—that lead to chronic and debilitating ill health and over 100 suffer at least one form of maternal morbidity.¹⁰ These devastating morbidities are caused, in part, by the majority of deliveries occurring outside of health facilities and without skilled attendants, and by delays in seeking and accessing care.¹¹ Morbidity rates are also high within health facilities, indicating the limited capacity, resources, supplies and skills available to clinics and hospitals as well as the barriers in access to care.¹²

The Government of Uganda has repeatedly expressed its commitment to improving maternal health. With the goal of “reduc[ing] mortality, morbidity, and fertility and the disparities therein,”¹³ the Uganda Health Sector Strategic Plan III (HSSP III) of 2010 to 2014 is dedicated towards improving reproductive health services in primary and secondary health¹⁴ facilities with a focus on maternal health.¹⁵ The Ugandan Government also launched the Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in 2008, which aims to improve the Ugandan healthcare system in the areas of maternal and newborn care.¹⁶ However, as the government’s report states: “[m]aternal health issues are yet to receive the required level of prioritization at both the policy and implementation levels.”¹⁷

The failure to prioritize maternal health issues is reflected most clearly in the government’s budgetary allocations. Although the government’s 2010/2011 budget allocated funds specifically to reduce maternal mortality and improve reproductive health for the first time,¹⁸ the allocations remain insufficient to meet the current need. According to the 2010/2011 health sector budget report, there remains an “unmet [n]ational need for Reproductive Health Supplies estimated at Ushs 7.5 billion”¹⁹ (over 3.3 million USD)—this represents the largest single unmet need for medicines and supplies in the 2010/2011 budget.²⁰ This unmet need

stems, in part, from the recent planned withdrawal of foreign donor support for the health sector; however, the Ugandan Government has failed to take appropriate steps to address the funding shortfall. The government has not moved to increase the overall budget allocation for the health sector, which has stagnated at approximately ten percent of the annual budget despite Uganda's commitment to a 15 percent health sector target under the Abuja Declaration.²¹ Further, according to news reports, maternal and child health receive the least funding within the health sector.²²

The implementation of the Road Map for maternal and reproductive health is slated to expand in 2010 with the establishment of maternal death review committees, the addition of emergency obstetrical facilities in 50 hospitals, and supplementation of basic equipment; however, it remains to be seen what progress can be made in practice given the budgetary constraints on the health sector.²³ No comprehensive tracking of the implementation of the Road Map is available, with only a cursory review provided in the 2010/2011 health budget stating that just 34 percent of the targeted districts have received the intended allocations without any mention of specific goals or strategies for improving maternal health.²⁴

The Committee has expressed concern when countries fail to report sufficient maternal mortality data²⁵ and recommended that states gather gender-disaggregated data to fully assess women's reproductive health needs.²⁶ Uganda has failed to structure systems to track maternal deaths and monitor women's maternal care, including antenatal and post-partum care, across the country.²⁷ The inability to track maternal healthcare data is compounded by the high proportion of women giving birth unattended (ten percent), attended by a relative (25 percent) or a traditional birth attendant (23 percent).²⁸ As a result, there are no mechanisms for following up with women who may need additional care and the lack of monitoring may also lead to inaccurate estimates of the prevalence of specific causes of maternal mortality and morbidity, such as complications from unsafe abortion.

Antenatal Care (ANC)

While data shows that most Ugandan women receive at least some ANC, the quality of that care is often gravely inadequate. Although 94 percent of Ugandan women who gave birth in the past five years had at least one antenatal care visit, the average gestational age at first ANC visit was 5.5 months.²⁹ This delay in accessing ANC can result in missed opportunities to diagnose, treat and prevent complications. Furthermore, less than half of women receive the minimum number of four ANC visits recommended under Uganda's minimum service requirements within its maternal health policy.³⁰

The quality of these ANC visits can be far from adequate, with many women never receiving required counseling on family planning, breastfeeding, maternal nutrition, delivery plans, or identifying risk symptoms during pregnancy.³¹ According to the 2007 Uganda Service Provision Assessment Survey (2007 USPAS), just 22 percent of the facilities that provide ANC services in Uganda carry all of the essential supplies necessary for basic ANC services.³² The majority of facilities lack the ability to diagnose common pregnancy complications and only six percent of facilities carry the minimum medications required to manage those complications.³³

Delivery Care

Access to, and quality of, delivery care is also a serious problem.³⁴ Although approximately half of all Uganda's health facilities offer basic delivery services, just five percent provide cesarean sections, and only one-quarter are able to provide minimum health services on a 24-hour

basis.³⁵ The 2007 USPAS reveals that less than half of facilities are equipped with transportation for maternity emergencies, which creates a significant obstacle in obtaining emergency obstetric care, particularly for the 58 percent of women who give birth outside of a health facility.³⁶ Less than half of facilities are equipped with the essential supplies to prevent infection during delivery, including soap, running water, disinfectant, and clean latex gloves.³⁷ Just one-third of facilities carry the basic equipment for conducting normal deliveries including scissors, clamps, and a suction apparatus.³⁸ Even those facilities that do carry supplies may be unable to properly sterilize instruments, with just ten percent equipped with the requisite sterilization materials.³⁹ Shortages are even more severe in the northern regions of Uganda: the government's failure to implement the Peace, Recovery and Development Plan for Northern Uganda (PRDP), which includes critical maternal healthcare objectives, reflects the ongoing marginalization and neglect of this region in terms of access to reproductive health services.⁴⁰

In addition to the lack of supplies, inadequacies in the number of healthcare providers as well as the skill level of birth attendants pose a grave threat to maternal health. Only approximately one half of health facilities are able to offer 24-hour delivery care by any type of trained medical provider, while just five percent have delivery protocols in place.⁴¹ In northern Uganda, just 35 percent of births are attended by any type of trained professional, and the number of skilled deliveries is the lowest in the country.⁴²

A recent study showed that, of the health facilities expected to be able to offer basic emergency obstetric care (EmOC), fewer than three percent could do so.⁴³ Only five percent of births occur in facilities equipped for emergency obstetric care.⁴⁴ One study showed that 86 percent of women who should have had some form of obstetrical intervention were unable to obtain it.⁴⁵ Of the few facilities that offer cesarean sections and other emergency procedures, just two-thirds are staffed with anesthetists.⁴⁶ The majority of hospitals and other health facilities are unable to provide blood transfusions, which is a critical barrier to addressing the fact that one quarter of all maternal deaths are caused by severe bleeding without remedy.⁴⁷

The barriers to care in rural areas, caused by the lack of medical staff, transportation, communication and EmOC capabilities, forces women into critical health circumstances. A recent news article highlighted the plight of Salome Nakitanda, who could not afford hospital care or transportation for her eleventh childbirth and barely survived an attempt by a traditional birth attendant (TBA) to provide an emergency cesarean. When complications arose, the TBA performed a cesarean using a kitchen knife after Salome fell unconscious during labor. During the procedure, the TBA sliced through Salome's uterus and bladder. Her baby died, and Salome was finally brought to the hospital where she required long-term treatment, including major reconstructive surgery.⁴⁸ This account illustrates the severity of preventable complications experienced by women living with minimal access to maternal healthcare.

Post-Partum Care (PPC)

Post-partum care (PPC) is defined by the WHO as the management of care for mother and infant up to 42 days after delivery.⁴⁹ The first 24 hours after delivery is

BARRIERS TO CARE IN RURAL AREAS

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ACCESS TO FAMILY PLANNING SERVICES AND INFORMATION

Access to family planning services and information is central to protecting women's and girls' rights to life and health. In the absence of contraceptive services, women may experience unwanted pregnancies, possibly resulting in death or illness due to lack of adequate healthcare, or they may seek out unsafe illegal abortions that can result in complications or death. Moreover, lack of contraceptive access affects women's right to control their fertility, the right to decide whether to have children and the number and spacing of children, and the right to self-protection against sexually transmissible infections (STIs) including HIV/AIDS.

the crucial window for preventing infant and maternal mortality by providing PPC and essential newborn care, with more than one-quarter of infant deaths around the world occurring within the first 24 hours of life.⁵⁰ Yet, according to the 2006 UDHS, about three-quarters of women overall receive no PPC whatsoever⁵¹ with only 11 percent receiving PPC in the first few hours after birth, and 23 percent of women receiving PPC in the first two days after birth.⁵² Rural women across Uganda are less likely than their urban counterparts to receive any PPC.⁵³

Obstetric fistula is a severe consequence of the lack of PPC and EmOC combined.⁵⁴ While data on the incidence of fistula in Uganda is poorly documented, estimates range in the number of 140,000 Ugandan women living with the condition, with a higher incidence in rural areas.⁵⁵ Without a coherent national policy or system for tracking obstetric fistula, the burden of treating and preventing this maternal morbidity is unmet. Only a handful of health facilities have trained professionals able to treat fistula, and prevention measures have not been implemented.⁵⁶

B. Access to Family Planning and Information

Access to family planning services and information is central to protecting women's and girls' rights to life and health. In the absence of contraceptive services, women may experience unwanted pregnancies, possibly resulting in death or illness due to lack of adequate healthcare, or they may seek out unsafe illegal abortions that can result in complications or death. Moreover, lack of contraceptive access affects women's right to control their fertility, the right to decide whether to have children and the number and spacing of children, and the right to self-protection against sexually transmissible infections (STIs) including HIV/AIDS.

In spite of this, access to contraception is undermined by a number of factors, including an inadequate and inconsistent supply of contraceptives, financial barriers, and shortcomings in providing family planning information. As a result, the unmet need for family planning services in Uganda is 41 percent, according to the 2006 UDHS.⁵⁷ More recent data collected by the Guttmacher Institute shows that this unmet need for family planning skyrockets in the North, where socioeconomic disadvantage and unrest create additional barriers for women, leading to an 84 percent unmet need for family planning in the region.⁵⁸

The overall contraceptive prevalence rate is just 24 percent in Uganda⁵⁹ and the use of modern contraceptive methods, namely hormonal birth control, injectables, and condoms, is just 15 percent.⁶⁰ According to the 2007 USPAS, one-third of births to women between the ages of 15 and 49 were mistimed, with 13 percent of pregnancies unwanted at the time of conception.⁶¹ The shortfall in family planning services means that Ugandan women on average have two more children than the number of children they desire.⁶² Lack of access to family planning also contributes to maternal deaths by depriving women of the ability to space their children and recover from pregnancies.⁶³

User fees, the unavailability of a preferred contraceptive method,⁶⁴ improper counseling services,⁶⁵ lack of information about contraceptive methods, and absence of supplies necessary to insert certain methods,⁶⁶ contribute to low

contraceptive prevalence in Uganda. Supply shortages of contraceptives in public health facilities are of particular concern. Recent reports show total shortages of contraceptives, leading directly to an increase in unwanted pregnancies and childbirths.⁶⁷ Uganda suffers an acute shortage of condoms, with a supply of just 80-120 million condoms imported by the government yearly, falling far short of the estimated need of over 220 million.⁶⁸ Stockouts of long-term contraceptive methods such as injectables at government facilities are also common, preventing women from accessing their family planning method of choice.⁶⁹ Due to a substantial reduction in foreign donor support for the health sector and the Ugandan Government's failure to allocate money to address the resulting funding gap,⁷⁰ Uganda continues to face a shortfall in contraceptive funding of USD 3 million (about 6 billion Ugandan shillings).⁷¹ Access to family planning supplies is particularly severe in northern Uganda, where conflict has damaged the infrastructure and destroyed basic health services in the region.⁷²

Emergency contraception (EC) is a vital tool in protecting and promoting women's reproductive rights; it is a particularly critical component of care for survivors of sexual violence, who are typically provided EC and post-exposure prophylaxis to reduce the chances of unintended pregnancy and HIV transmission, respectively. Improved access to EC would reduce the cost of unintended pregnancy in Uganda by 75 percent and would significantly reduce the number of abortions and thereby the number of maternal deaths related to unsafe abortion.⁷³

However, despite the fact that EC was officially introduced by Uganda's Ministry of Health in 1998,⁷⁴ EC use remains low and studies show a lack of awareness of the method.⁷⁵ The government's release of EC was accompanied by widespread media promotion, which provoked significant resistance by local groups, including religious groups.⁷⁶ Despite the media campaigns, less than half of university students surveyed in 2005 had ever heard of EC; this lack of knowledge further increased misinformation about correct usage and amplified fears of the risks of using EC.⁷⁷ The 2007 USPAS shows that the number of women in Uganda who have ever used EC in Uganda is close to zero, while just 18 percent of health facilities across Uganda report supplying EC.⁷⁸ One study suggests that EC is more likely to be available in the capital, Kampala, than in other parts of the country,⁷⁹ while the 2007 USPAS confirms that EC is more frequently found in hospitals than other types of health facilities.⁸⁰ This data indicates that women in rural areas, or areas that are not in close proximity to a hospital, are even less likely to be able to access EC.

Healthcare workers also lack accurate information about EC and may project unfavorable attitudes towards patients seeking EC, which reduce its use and acceptance.⁸¹ There is insufficient training on the proper use of, and counseling on, EC.⁸² Common misperceptions of EC include the notion that it will inhibit future fertility, encourage sexual promiscuity, and cause extreme side effects.⁸³

In addition, EC should be available to women and girls who have survived rape, particularly in light of the widespread incidence of sexual violence in Uganda. However, women who have survived sexual violence fear the stigmatization of revealing their experience, and also may face delays in accessing EC that undermine its effectiveness, particularly in the northern regions where sexual violence is rampant and services are minimal.⁸⁴

C. Adolescent Reproductive Health

The CEDAW Committee has asked states to pay particular attention to “the health education of adolescents, including information and counseling on all methods of family planning,”⁸⁵ and has specifically recommended that states, including Uganda, develop preventive programs to address the problem of high rates of adolescent pregnancy,⁸⁶ and unsafe abortion.⁸⁷ The Committee has also recognized sexual abuse of girls by older men as a violation of their reproductive rights⁸⁸ and has expressed grave concern over violence against girls in conflict zones,⁸⁹ highlighting the importance of redress for civilian victims of sexual violence during armed conflict.⁹⁰

Sexual and reproductive health information and services for adolescents remain drastically inadequate in Uganda. Adolescents begin sexual activity early in Uganda compared to other sub-Saharan African countries.⁹¹ While general awareness of HIV is widespread, a high percentage of adolescents are not aware of other STIs, and in-depth knowledge of how to prevent HIV and other STIs remains poor.⁹² Adolescents lack knowledge of proper condom use and are at particular risk of engaging in poor preventive behaviors, which in turn increase the risk of transmitting HIV.⁹³ The underlying reason for risky behaviors and misinformation amongst adolescents is the failure of the Ugandan Government to tailor services and programs to adolescent needs.⁹⁴

Adolescent women remain at particular risk of HIV transmission. Women aged 15 to 24 are more than twice as likely as their male counterparts to have HIV/AIDS.⁹⁵ This disproportionate risk to women is rooted in social and cultural factors that lead to women beginning sexual activity at younger ages, often due to early marriage,⁹⁶ as well as the prevalence of coerced sex and age disparities between young girls who have sex with older men.⁹⁷ Particularly vulnerable subgroups of adolescent women include street children, sex workers, displaced persons, and orphans.⁹⁸ Health centers are not sufficiently targeted towards young people,⁹⁹ and much of the sexual health information and education that empowers adolescents to protect themselves from HIV is limited to the school context, making it unavailable to young women who are 6 times more likely not to attend school than their male counterparts.¹⁰⁰ Because sexuality education in schools is neither comprehensive nor age-targeted, many students are unable to access information about HIV risks and prevention until after they become sexually active.¹⁰¹

The lack of critical adolescent sexual and reproductive health information and services also contributes to high rates of teenage pregnancy: Uganda’s adolescent pregnancy rate is amongst the highest in the world.¹⁰² Over one-quarter of young women have begun childbearing by age 17, with close to 60 percent of women having given birth to one or more children by age 19.¹⁰³ The high rate of births to teenage mothers is a serious concern because of the association between young maternal age and greater risk of infant and maternal mortality and morbidity. According to the Uganda National Development Plan, the culture of early marriages amongst girls increases the rate of early pregnancies and is partly responsible for the country’s high maternal mortality rate.¹⁰⁴ The median age of marriage for girls in Uganda is 17.8 years.¹⁰⁵ Early marriage is associated with higher fertility rates and a longer period of childbearing thereby exposing women to repeated maternal mortality and morbidity risks.¹⁰⁶

High rates of teenage pregnancy may also be attributed, in part, to high rates of sexual violence against young girls and women in Uganda—particularly in schools. In Uganda, 23 percent of girls reported that their first sexual encounter was forced, and studies have shown

a link between early coercive sex and failure to use preventive measures such as condoms for fear of violence.¹⁰⁷ A disturbing proportion of this sexual violence against girls occurs in schools. In one recent study, over 75 percent of Ugandan children between the ages of eight and 18 reported some form of sexual violence or harassment, with 24 percent of children reporting that this violence occurs mainly in school, and 34 percent reporting that it occurs both at home and at school.¹⁰⁸ Further, girls are the most likely targets of sexual violence and have a higher probability of suffering ill health effects as a consequence of sexual violence, including drug use and risky sexual behavior.¹⁰⁹ A 2008 study revealed that eight percent of 16 and 17 year old Ugandan girls have had sex with their teachers.¹¹⁰ Teachers often lure girls by promising good grades or threaten them to prevent them from reporting the violence. Sexual abuse in schools also results in poor school performance, unintended pregnancy, absenteeism, and early school-leaving.¹¹¹ Violence against women and girls is particularly extreme in the northern districts, where thousands of girls were abducted to be used as sex slaves during the conflict, and where the lack of police officers means that there may be no legal recourse for survivors of sexual violence.¹¹²

The lack of access to sexual and reproductive health services and information and the high rates of sexual violence mean that many Ugandan adolescents are forced to deal with unwanted pregnancies. In its 2002 Concluding Observations on Uganda, the Committee expressed its concern about the impact of adolescent pregnancy on “girls’ enjoyment of the rights in the Convention, particularly in the spheres of education and health.”¹¹³ A 2005 report documents the continuing stigma and discrimination experienced by pregnant adolescents and its impact on their rights to health and education: pregnant young women—particularly those who are unmarried—are subject to violence by family members and may be sent away from their homes, are expelled from school, and receive “rude, abusive and threatening” treatment from healthcare workers when they attempt to seek care in connection with their pregnancy.¹¹⁴ These experiences of stigma and discrimination push some young women to procure unsafe abortions,¹¹⁵ placing their lives and health at serious risk. The Committee acknowledged this fact in its previous Concluding Observations for Uganda, expressing concern at “the high rate of maternal mortality among teenage girls, particularly in the rural areas, frequently as a result of clandestine abortion.”¹¹⁶

D. Unsafe Abortion and Post-Abortion Care

The Committee’s General Recommendation 24 states that “barriers to women’s access to appropriate healthcare include laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures.”¹¹⁷ The Committee has often framed restrictive abortion laws as a violation of the rights to life and health.¹¹⁸ As such, it has asked states to review legislation that makes abortion illegal¹¹⁹ and recommended that states remove punitive provisions for women who undergo abortion,¹²⁰ in line with the Committee’s General Recommendation 24 and the Beijing Declaration and Platform for Action.¹²¹ The Committee also explicitly calls for the removal of impediments to women’s access to lifesaving health services (such as high fees, spousal authorization, or punitive provisions imposed on women who undergo abortions).¹²²

Unsafe abortion is one of the most easily preventable causes of maternal death and disability. Unsafe abortion also causes grave morbidities, and women may experience long-term harm such as uterine perforation, chronic pelvic pain, or infertility.¹²³ Each year an estimated total of 297,000 induced abortions (both legal and illegal) are performed in Uganda with

nearly 85,000 women treated for complications.¹²⁴ Approximately 1,200 women die each year from unsafe abortions.¹²⁵ Although there are no official statistics on abortion or abortion complications, it is clear that unsafe abortion is a leading cause of maternal morbidity and mortality in Uganda.¹²⁶ A recent submission from Uganda to the All-Party Parliamentary Group on Population, Development and Reproductive Health puts the percentage of maternal deaths attributable to unsafe abortion at 26 percent.¹²⁷

Despite Uganda's stated commitment to improving maternal health, its abortion law and policies are characterized by restrictiveness and a lack of clarity. The Penal Code classifies abortion as a felony and criminalizes abortion except to save the life of the pregnant woman.¹²⁸ The Ugandan Constitution states that "[n]o person has the right to terminate the life of an unborn child except as may be authorized by law."¹²⁹ Domestic judicial interpretation of abortion rights in Uganda has acknowledged that "unsafe abortion is an infringement of women's rights" that must be prevented and addressed, despite maintaining that abortion is illegal.¹³⁰ Although Uganda recently ratified the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol),¹³¹ which supplements the African Charter and provides broad protections for women's human rights, the government reserved on Article 14(1)(a), which guarantees women the right to control their fertility.¹³² The government further reserved on Article 14(2)(c), which would have authorized access to safe abortion services, including where necessary to preserve the woman's health and in cases of rape and incest.¹³³

Uganda's National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights (Reproductive Health Guidelines) detail an expanded scope of circumstances permitting legal abortion, such as sexual violence and incest, and outline comprehensive abortion and post-abortion care standards.¹³⁴ In practice, however, doctors and other trained providers are reluctant to provide the comprehensive services outlined in the Guidelines and are unwilling to be potentially subject to criminal liability under the Penal Code. Doctors may even refuse to perform post-abortion care, and women are likewise afraid to seek professional abortion-related care, for fear of being reported to the police.¹³⁵ The stigma and fear associated with abortion affects funding allocation as well: one recent study on health spending in Uganda concluded that "highly sensitive issues, such as abortion . . . are consciously being neglected and under-funded."¹³⁶

The poorer a woman is, and the more rural her location, the less likely she is to seek abortion services from a trained or licensed healthcare professional. Poorer women are more likely to have clandestine abortions, often in unsanitary conditions at the hands of untrained practitioners, greatly increasing the risk of abortion-related complications.¹³⁷ Less safe providers perform over half of the abortions occurring in poorer, rural areas throughout Uganda.¹³⁸ A survey of healthcare providers found that the percentage of abortions performed by doctors drops from 50 percent for non-poor urban women to ten percent for poor rural women.¹³⁹ Girls are also less likely to be able to access and afford safe abortion services and may feel additional pressure to terminate a pregnancy because of the social stigma of pregnancy and the difficulties of continuing their education. However, even abortions performed by trained healthcare providers may still be unsafe because, as one doctor at Makerere University explained, "[m]any of our doctors have not been well trained to offer safe methods or are working under unsafe conditions."¹⁴⁰

Uganda's health facilities are also poorly equipped to manage post-abortion care (PAC). Vacuum aspirators¹⁴¹ and dilation and curettage (D&C)¹⁴² kits—supplies critical to the provision of PAC—are available in 22 percent and 14 percent, respectively, of the health facilities offering delivery services.¹⁴³ Delivery service providers receive less training in PAC than almost any other area of skills training, with just eight percent of providers receiving training in the year preceding the 2007 USPAS.¹⁴⁴ Private facilities are more likely than government facilities to offer appropriate PAC services, but the cost of these services makes them prohibitive for many women.¹⁴⁵ A survey of Ugandan women also suggests that women do not seek medical treatment for abortions or related complications because they fear negative reactions and judgment from healthcare providers.¹⁴⁶ Only 51 percent of poor rural women who suffer abortion complications seek medical assistance.¹⁴⁷ Even when women do seek post-abortion care, “the drugs, equipment and skills are insufficient” noted an Assistant Commissioner for Reproductive Health in the Ministry of Health.¹⁴⁸ The lack of access to safe abortion services increases the burden on the Ugandan healthcare system, particularly public hospitals which treat the most severe abortion-related complications,¹⁴⁹ and places Ugandan women at risk of long-term disabilities or death.

A recent news article demonstrates the dire harm caused by restrictive abortion laws and women's lack of access to post-abortion care. In the article, a senior midwife at Jinja Regional Referral Hospital maternity wing in eastern Uganda reports that the majority of the cases treated at the maternity wing are complications from abortion because “abortion is hurriedly and secretly done”—according to the midwife, they receive approximately 30 abortion cases per week.¹⁵⁰ Women who live in the county but cannot reach Jinja Hospital may turn to their local health center; however, many lower level health centers in the district “do not have the medical supplies or sufficiently trained health professionals to provide post-abortion care.”¹⁵¹ As a result, women with cases of incomplete abortion who seek care locally often die because they seek assistance too late, because ambulances are scarce and taxi drivers refuse to transport them to Jinja once sepsis has caused a foul odor, and because the health centers lack critical supplies, such as “strong antibiotics for abortion cases,” to treat post-abortion care patients.¹⁵²

E. STI and HIV Services for Women

Accurate information on prevention and treatment of STIs is a key component of sexual and reproductive health. The CEDAW Committee has noted that “issues of HIV/AIDS and other sexually transmitted diseases are central to the rights of women and adolescent girls to sexual health,” and has urged states to ensure “without prejudice and discrimination, the right to sexual health information, education and services for all women and girls.”¹⁵³

Uganda has failed to prevent discrimination against women and girls on the basis of HIV status and, in fact, has proposed legislation that would exacerbate such discrimination. Uganda has also failed to provide adequate health services and access to preventive measures, including family planning services and information, to empower women against HIV/AIDS and other STIs.

DISCRIMINATION BASED ON HIV STATUS

Uganda has failed to prevent discrimination against women and girls on the basis of HIV status and, in fact, has proposed legislation that would exacerbate such discrimination. Uganda has also failed to provide adequate health services and access to preventive measures, including family planning services and information, to empower women against HIV/AIDS and other STIs.

HIV/AIDS Rates

Despite the praise that Uganda has received as a country that successfully implemented a campaign against HIV/AIDS throughout the 1990s, Uganda still faces a severe HIV epidemic.¹⁵⁴ By 2007, a cumulative total of approximately 2.6 million people in Uganda had contracted HIV.¹⁵⁵ Of these people, approximately 1.6 million have died and roughly one million are living with HIV.¹⁵⁶ In addition, about 1.2 million children have been orphaned by AIDS.¹⁵⁷ The current HIV prevalence rate in Uganda is estimated to be 6.4 percent,¹⁵⁸ with prevalence higher among adult women (7.5 percent) as compared to men (five percent).¹⁵⁹ Additionally, prevalence rates are higher among young women aged 15 – 24 (3.9 percent) than young men of the same age (1.3 percent).¹⁶⁰ While, overall, women living in urban areas have a significantly higher risk than women in rural areas, the HIV prevalence rate in the rural northern region is particularly high for women.¹⁶¹ Sex workers are the population at highest risk, with an overall HIV prevalence of 47.2 percent.¹⁶²

Recently, Uganda has experienced an increase in the number of new HIV cases reported,¹⁶³ which may be partially attributable to the government's emphasis on abstinence-based prevention programs, which are detrimental to Ugandan women.¹⁶⁴ Uganda lacks a comprehensive approach to addressing HIV/AIDS that incorporates the prevention of mother to child transmission, including through family planning, the prevention and treatment of STIs, and other innovative interventions to supplement the abstinence until marriage approach.¹⁶⁵

An emphasis on abstinence until marriage is both flawed and dangerous since women are often forced into non-consensual sexual relations and marriage itself can actually be a risk factor for contracting HIV.¹⁶⁶ Data demonstrates that men are increasingly engaging in extramarital sex; at the same time, married individuals are “least likely to use condoms.”¹⁶⁷ Significantly, most married couples are sero-discordant (meaning that one partner is HIV-positive and not the other), thus married persons are at particular risk of transmission, indicating that counseling, testing and education measures must be tailored to the needs of these couples.¹⁶⁸

As in other countries, people living with HIV suffer stigma and discrimination in Uganda¹⁶⁹ and HIV-positive women are often victims of violence because of their HIV status.¹⁷⁰ Despite the existence of HIV/AIDS programs, which aim to fight such attitudes and to encourage those living with HIV to seek treatment and support, attitudes have been slow to change in Uganda. As a result of this persistent stigma and a fear of violence, many women fear learning and disclosing their HIV status and having their partners accuse them of bringing HIV into the home, as the women may then be evicted or subjected to domestic violence.¹⁷¹ In 2008 alone, five cases were reported of women being murdered by their husbands once they learned that their wives were HIV-positive.¹⁷²

Harmful Implications of the HIV and AIDS Prevention and Control Bill, 2010 on Women's Health

The Ugandan Parliament was considering a draft bill titled the “HIV and AIDS Prevention and Control Bill, 2010” (the HIV Bill), which was introduced before Parliament on May 19, 2010 and tabled for the first reading.¹⁷³ While the bill is currently shelved due to intensive advocacy against it, the fact that such legislation progressed as far as it did is highly problematic. The Ugandan Parliament introduced this legislation in response to research findings demonstrating that Uganda's HIV prevalence rate had stagnated at around 6.5 percent and indicating that an

increasing number of infections occurred among married couples.¹⁷⁴

Several of the HIV Bill's provisions threaten to negatively impact women, including provisions that criminalize transmission of HIV/AIDS, permit non-consensual disclosure of one's status, and allow mandatory HIV testing without patient consent in certain circumstances. The HIV Bill provides for "[r]outine HIV testing" for victims of sexual offences, pregnant women, and partners of pregnant women without an informed consent requirement¹⁷⁵ and people "convicted of an offence involving prostitution" are "subjected to HIV testing for purposes of criminal proceedings and investigations."¹⁷⁶ No guidance is given in any of these circumstances on informed consent, leading human rights experts to interpret these clauses as the equivalent of mandatory testing.¹⁷⁷

Mandatory testing of sexual violence survivors risks increasing harm to these survivors, as well as marginalizing women and sex workers in particular, who are more likely to fall under this category.¹⁷⁸ Mandatory testing will foster discrimination in the healthcare system against these populations and increase the stigma faced by survivors of sexual violence, which creates barriers to HIV treatment and discourages the reporting of sexual violence.

Compulsory testing of pregnant women may likewise discourage women from seeking healthcare, which, in turn, would undermine the Ugandan Government's ability to prevent the spread of HIV and improve maternal health. The International Guidelines on HIV/AIDS and Human Rights recognize that the compulsory testing of pregnant women is a coercive measure that ineffectively combats the spread of HIV and restricts the human rights of the individual,¹⁷⁹ which can result in "reduced participation and increased alienation of those at risk of infection."¹⁸⁰

Even when pregnant women learn their HIV status, appropriate treatment is often not available. PMTCT treatment is only integrated into ANC and delivery services at 43percent of health facilities in Uganda.¹⁸¹ Rather than focusing on compulsory testing of pregnant women, efforts would be better directed at strengthening the delivery of maternal health and PMTCT services and increasing women's confidence in maternal health services.

Clause 23 of the HIV Bill allows healthcare providers to release the results of an HIV/AIDS test to a client's sexual partners without the client's consent.¹⁸² Nonconsensual disclosure of women's status exposes them to stigma, discrimination, and violence.¹⁸³ If women fear that healthcare providers will disclose their HIV status to their partners without their consent, they may be discouraged from seeking healthcare services, which could undermine the government's public health initiatives around HIV and reproductive health.¹⁸⁴

Clause 41 of the HIV Bill criminalizes the intentional transmission of HIV and provides for harsh criminal penalties, exposing HIV-positive women to further risks of human rights violations.¹⁸⁵ Women are more likely to learn of their sero-status because HIV testing is routinely provided as part of prenatal healthcare, making them more vulnerable to charges from their male partners of intentional HIV transmission. Additionally, imposing criminal penalties on the intentional transmission of HIV stigmatizes people living with HIV, who may choose to forego HIV treatment and care for fear of incurring criminal liability in the process. The criminalization of HIV transmission is ineffective in combating the spread of HIV; instead, it threatens to undermine HIV prevention efforts and exacerbate the stigma and discrimination already experienced by people living with HIV, particularly women, when they seek access to

HEALTHCARE COSTS IMPACT ON ACCESS

Healthcare costs—which can include the cost of the health goods or services, fees for transportation, food, supplies or drugs that must be purchased and brought to the facility, and informal charges—can prevent or delay women from accessing services, and can impose additional health risks and hardship. User fees, in general, tend to hit women harder than men and present a considerable barrier to women’s access to maternal healthcare and family planning services in Uganda.

health facilities.

Prevalence and Treatment of Other STIs and Cervical Cancer

The CEDAW Committee has expressed concern over rising rates of STIs,¹⁸⁶ with particular concern regarding higher STI infection rates for women than men.¹⁸⁷ The Committee has also asked governments to take a human rights-based¹⁸⁸ and gender sensitive¹⁸⁹ approach against HIV and STIs, and has previously asked Uganda to implement practical prevention methods including promoting condom use.¹⁹⁰ The prevalence of STIs in Uganda is extremely high. Within the age 15-49 bracket, 49 percent of women and 38 percent of men have the Herpes Simplex 2 Virus, ten percent of men and women have Hepatitis B and three percent of men and women have syphilis.¹⁹¹ Many are unaware that they have an STI and amongst previously untested persons who have ever been sexually active but reported no symptoms, half of women and 40 percent of men tested positive for herpes.¹⁹²

Uganda also has amongst the highest prevalence rates and lowest survival rates for cervical cancer, the most common cause of death for Ugandan women outside the childbearing age bracket.¹⁹³ Only 13 percent of women survive cervical cancer in Uganda,¹⁹⁴ as measured by the five-year age-standardized relative survival. The main factors contributing to this excessive death rate from cervical cancer are the failure to detect cancer or precancerous cell changes at an early stage,¹⁹⁵ and poor quality and access to healthcare services.¹⁹⁶ Prior studies have also found that the great majority of cervical cancer patients in Uganda have HPV, with HPV type 16 present in 53 percent of women with cervical cancer.¹⁹⁷ Without comprehensive vaccination programs and screening, the number of women developing and dying from cervical cancer will only increase.

II. THE RIGHT TO BE FREE FROM DISCRIMINATION, INCLUDING GENDER-BASED VIOLENCE (ARTICLES 1, 2, 12, 14, AND 16)

The Convention defines discrimination against women as “any distinction, exclusion or restriction made on the basis of sex which has the *effect or purpose* of impairing or nullifying the recognition, enjoyment or exercise by women ... of human rights and fundamental freedoms.”¹⁹⁸ Accordingly, the Committee has determined that an act “directed against a woman because she is a woman or that affects women disproportionately” constitutes gender-based discrimination.¹⁹⁹

States are obligated under CEDAW to take steps to eliminate sex-based discrimination by both public and private actors.²⁰⁰ This requirement of non-discrimination permeates all of Uganda’s duties under CEDAW, including the obligation “to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services” [Article 12(1)]; the obligation “to eliminate discrimination against women in rural areas in order to ensure ... access to adequate health care facilities” [Article 14(2)]; and the obligation “to eliminate discrimination against women in all matters related to marriage and family relations [and to] ensure, on a basis of equality of men and women ... [t]he same rights to decide freely and responsibly on the number and spacing of their children” [Article 16(1)(e)]. In addition, the CEDAW Committee has affirmed that states have an obligation under the Convention “to

eliminate all forms of violence against women,” because discrimination against women includes gender-based violence.²⁰¹ Women seeking healthcare services in Uganda encounter discrimination based on their income, age [see Adolescent Reproductive Health section], gender, place of residence and occupation.

A. Discrimination in Healthcare

Healthcare costs—which can include the cost of the health goods or services, fees for transportation, food, supplies or drugs that must be purchased and brought to the facility, and informal charges—can prevent or delay women from accessing services, and can impose additional health risks and hardship. User fees, in general, tend to hit women harder than men and present a considerable barrier to women’s access to maternal healthcare and family planning services in Uganda.

Across each area of maternal healthcare provision in Uganda, grave disparities of access and quality distinguish government and private health facilities. Although private facilities are more likely to carry essential medical supplies and equipment, they are also more likely to charge user fees. Where fees are charged, facilities fail to monitor and publicize fee schedules.²⁰² The ability to pay is cited by women as the greatest obstacle to their ability to access maternity care, and rural women are disproportionately impacted by user fees.²⁰³ In addition, although care is supposed to be free of charge in the public health sector,²⁰⁴ in practice, user fees, as well as fees for medical supplies, tests, registration fees and medication, are frequently levied.²⁰⁵ As a consequence, women seeking maternal healthcare are forced to pay.²⁰⁶

A similar situation applies to women seeking family planning services.²⁰⁷ The 2006 UDHS documents that contraceptives are far more likely to be free in public health facilities than in private facilities and, where fees are charged for contraceptives in the public sector, prices are typically lower than in the private sector.²⁰⁸ However, despite the greater affordability of public sector services and goods, the greatest single source of contraceptives for Ugandans is private hospitals and clinics.²⁰⁹ The government’s failure to commit funds to family planning commodities, and the subsequent family planning supply shortages, shift the responsibility to meet women’s family planning needs to the private sector, which is more likely to charge user fees.²¹⁰ These costs are prohibitive for many in a country where the gross national income per capita is just USD 420²¹¹ and over 75 percent of the population lives on less than USD 2 a day.²¹²

Women living in poverty, in rural areas, and particularly in the conflict-stricken northern regions of Uganda, face the most extreme barriers to protecting and fulfilling their reproductive and sexual health and rights.²¹³ For example, according to the 2006 UDHS, rural women are more likely than urban women to report challenges in accessing healthcare—60.2 percent of rural women cite distance to the health facility as a challenge, compared to 26.1 percent of urban women; similarly, 54 percent of rural women report the need for transportation as an obstacle, versus 23.9 percent of urban women.²¹⁴ In addition, some internally displaced persons camps in the north have reported the complete unavailability of medication to prevent mother-to-child transmission of HIV and shortages of antiretrovirals (ARVs).²¹⁵

Sex workers also contend with additional barriers to access, and evidence shows that sex workers face the highest risk of HIV infection (47.2 percent) while just 58 percent of clients report using condoms.²¹⁶ Sex workers face discrimination by health workers and police

alike, which discourages them from accessing essential reproductive and sexual healthcare services.²¹⁷

Sexual minorities also encounter discrimination in access to healthcare—a recent report on healthcare spending in Uganda found that reproductive health services for sexual minorities are “consciously being neglected and under-funded,” evidence of the discrimination and stigma faced by this marginalized population.²¹⁸

Finally, gender inequities also form a major obstacle to women’s access to sexual and reproductive health services in Uganda. Nearly 40 percent of women say that their male partner plays the primary decision-making role over their healthcare, and half of men believe it is a man’s role to decide on the number of children a couple will have.²¹⁹ This gender inequity limits women’s ability to prevent pregnancy and the transmission of STIs and to seek assistance for complications in pregnancy and childbirth.²²⁰

B. Gender-Based Violence and Discrimination

The Committee has previously expressed concern about the high incidence of sexual violence against women in Uganda,²²¹ calling on Uganda to address the persistent patriarchal patterns of behavior and “the existence of stereotypes relating to the role of women,” which perpetuate violence and discrimination against women.²²² Gender-based violence, however, particularly sexual violence against women and girls, continues to be a serious and pervasive problem in Uganda.

According to the 2006 UDHS, 68 percent of ever-married women experienced some form of violence by their husband or intimate partner.²²³ Death from domestic violence in Uganda has increased in recent years, with 165 cases reported to the Uganda Police in 2009, marking a 20 percent increase in just one year.²²⁴ 60 percent of women suffer physical violence, with their husband or partner as the most common perpetrator.²²⁵ Over half of ever-married women are subject to physical or sexual violence and women who are married and between the ages of 25 and 39 are at greatest risk of violence.²²⁶ Cultural and societal views perpetuate violence against women, with 70 percent of women believing that physical violence against women is justifiable in at least certain circumstances.²²⁷

According to the same 2006 UDHS survey, approximately one-quarter of women aged 15 to 49 reported that the first time they engaged in sexual intercourse was against their will.²²⁸ Additionally, about four in ten Ugandan women experience sexual violence during their lifetimes.²²⁹ Of those women who do suffer sexual violence, approximately 66 percent experience such violence at the hands of a current or former husband or partner.²³⁰ Yet, despite these high rates of sexual violence, the Sexual Offences Bill remains pending in Uganda’s Parliament, six years after it was first introduced.²³¹

Victims of sexual violence are exposed to the possibility of contracting HIV from their assailant. Yet, healthcare system weaknesses mean that survivors of sexual violence have difficulty accessing the post-exposure prophylaxis (PEP) necessary to prevent contracting HIV following a sexual assault.²³² This problem is particularly acute in remote areas of northern Uganda²³³—healthcare workers have been reluctant to serve the population in northern Uganda in recent years due to active conflict, resulting in a desperate lack of reproductive and sexual health services.²³⁴ As the staff member of one women’s rights organization explained, “PEP could be

available in health units, but when we refer the survivors there for medication, they find no one to help them. There is a shortage of doctors.”²³⁵

Even when victims do report rape, the Ugandan judicial system fails to pursue justice and women face indifference to these crimes and impunity for their assailants. A survey of rape and defilement cases in northern Uganda revealed that fewer than two percent of reported rape cases resulted in a conviction, and less than six percent of defilement cases resulted in a conviction.²³⁶ A significant number of victims cited the total lack of affordable legal assistance, coercion by perpetrators, and backlogged courts as reasons why cases were dropped.²³⁷

In addition, public attitudes about rape and sexual violence are amplified by the media, which exacerbates the stigma against women and survivors of sexual violence. For instance, in 2009, a Ugandan doctor who was raped and robbed was then publicly humiliated by a newspaper which wrote an article graphically discussing her rape and disclosing her name to the public, perpetuating the stigma and discrimination she already faced.²³⁸

C. Harmful Traditional Practices

Status of Women and Views on Marriage

The CEDAW Committee has issued guidelines on equality in marriage and requires states to apply the principles of equality and justice regardless of the particular legal system, religion, custom or tradition applicable in the country or region.²³⁹ The Committee has expressed concern that custom, tradition, and the failure to enforce national constitutions and laws have resulted in instances of polygamous marriage and forced or arranged marriages.²⁴⁰ In its General Recommendation 19, the Committee defines forced marriage as a form of violence against women and as perpetuating their subordinate role in society.²⁴¹

Polygamy is legal in Uganda and women lack legal recourse to prevent their husband from marrying additional wives.²⁴² The power to make decisions regarding health, reproduction, and children remains in the hands of men.²⁴³ This power imbalance poses increased health risks, including the risk of contracting HIV and other STIs, by depriving women of the power to negotiate condom use. The Marriage and Divorce Bill, which includes provisions on equality in marriage and in the family, addresses “women’s right to negotiate sex on the ground of health,” and would go a long way towards addressing these gender inequalities.²⁴⁴ However, despite repeated attempts by women’s groups to push for the bill’s passage, Parliament has repeatedly shelved the bill and delayed the legislative process for almost two decades.²⁴⁵

Early and Forced Marriage

The CEDAW Committee has identified 18 as the appropriate legal age of marriage for both men and women²⁴⁶ and has rejected arguments in support of an earlier marriage age for girls because of the associated health risks.²⁴⁷ The minimum legal age for marriage in Uganda is 18 for both men and women; however, in practice, the cultural preference for early marriage is widespread, with the 2006 UDHS estimating that over 15 percent of girls between 15 and 19 years of age were married, widowed or divorced.²⁴⁸

Early marriage exposes women to increased risks of maternal mortality and morbidity. Younger mothers are at particular risk for complications such as obstetric fistula because pelvic growth is not complete.²⁴⁹ Adolescent women are less likely to seek antenatal care and more likely to suffer complications and require cesareans; complications from pregnancy, abortion and

childbirth remain the leading cause of death for women between the ages of 15 and 19.²⁵⁰ Early marriage also exposes girls to coerced sex and studies show that younger women are more susceptible to coerced sex.²⁵¹

In northern Uganda, particularly in refugee camps and settlements, the practice of abducting and forcing young girls to marry and bear children has been a systematic violation of women's rights.²⁵² Thousands of girls and young women were abducted and forced into marriage and sexual service by members of the Lord's Resistance Army (LRA) during the conflict, and the practice of systematic sexual violence and forced marriage has continued since the cessation of hostilities.²⁵³ Half of all forced wives gave birth to children, of which one quarter gave birth at age 18 or younger, and nearly half of LRA commanders had five or more forced wives given to them as a reward for their participation in the violence.²⁵⁴

The practice of early marriage is sometimes a response to cover the stigma faced by girls who have already been sexually abused. In this region, conflict has disrupted society such that rape is now utilized in some instances to force girls and adolescents into marriage²⁵⁵ and these forms of violence against women have become normalized. Young women who were abducted, then forced into marriage and childbearing, and later returned with their children, are less likely to access education by one third; they are also less likely to be employed and are likely to earn less than their counterparts who were not abducted.²⁵⁶ These young women also face the highest rates of sexual violence in their communities and there continues to be little or no legal remedy available to these women.²⁵⁷

Female Genital Mutilation

The CEDAW Committee has identified female genital mutilation (FGM) as a threat to women's rights to life and physical integrity as well as social and economic equality²⁵⁸ and underscored states' responsibility to stop this form of violence against women.²⁵⁹ The Committee also identified the practice as discriminatory in its 1995 concluding observations to the Government of Uganda.²⁶⁰ FGM is correlated with early marriage, earlier age of first childbirth, and increased rates of HIV transmission.²⁶¹ FGM has been recently banned in Uganda²⁶² and also found to be inconsistent with Uganda's Constitution and international treaty obligations in a recent constitutional court decision citing the deaths associated with the practice of FGM.²⁶³ Despite these legal prohibitions, there is a lack of sensitization and awareness-raising to support the implementation of the law in regions of Uganda where girls are at the greatest risk of community coercion and pressure to undergo FGM.²⁶⁴ Uganda continues to face challenges in implementing the FGM ban because of the strong social stigma still associated with not undergoing FGM—resulting in the abuse and exclusion of women who have not undergone FGM.²⁶⁵

We hope that the Committee will consider addressing the following questions to the Government of Uganda:

Maternal Health and Family Planning Services

1. What steps is the government taking to ensure implementation of the 2008 Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda 2006-2015? Has the government outlined quantifiable goals with a monitoring and

evaluation system to track the implementation of the Road Map?

2. What steps has the government taken or does the government plan to take to ensure that all healthcare services including medication and supplies that are intended to be free of charge do not incur user fees in practice? What other measures are being taken to eliminate the financial barriers faced by women seeking family planning, maternal healthcare and other services?
3. What measures are being taken to ensure sufficient supplies of family planning and contraceptive methods, particularly the long-term methods preferred by women in Uganda, to avoid the stockouts of 2010? What is the government doing to ensure its stock of condoms is sufficient to meet the national need? What steps is the government taking to improve awareness about, and the availability of, emergency contraception?
4. What does the government plan to do to address obstetric fistula and remedy the fact that currently there is no national policy, no tracking system, and a limited number of trained professionals able to treat obstetric fistula?
5. What programs has the government implemented to improve the tracking and monitoring of maternal and reproductive healthcare, specifically to improve the number of women receiving the recommended antenatal care and to gather information about the incidence and causes of maternal mortality and morbidity? What measures have been taken to improve data collection related to the incidence of unsafe abortion?

Access to Safe and Legal Abortion

6. Is there any law that operationalizes the constitutional provision on abortion stating that “[n]o person has the right to terminate the life of an unborn child except as may be authorized by law”? What steps are being taken to reconcile the criminal law exception for abortion to save the life of the woman with the broader range of exceptions in the Reproductive Health Guidelines? How will the government ensure effective implementation of the provisions on access to safe abortion in these guidelines? What steps will the government take to ensure that healthcare providers are aware of, and adhering to, these guidelines?
7. What measures has the government taken to address the stigma and discrimination associated with unsafe abortion and to encourage women with abortion complications to seek medical care? How will the government address the lack of trained staff and equipment and the limited funding allocations for abortion-related services?
8. What are the Ugandan Government’s reasons for having reservations to the Maputo Protocol? In view of the current East African Community, does the reservation affect the harmonization of the national legislation, particularly where Tanzania ratified without reservations? Are there any plans to lift the reservations? When is the national legal framework for safe abortion going to be put in place or clarified? What measures have government put in place to ensure the rights of children who are born as a result of sexual violence and abandoned by both parents?

Adolescents

9. What measures has the government taken to improve sexual health education, particularly for adolescents and youth? How does the government plan to ensure that youth who do not attend school receive comprehensive sexual health education?
10. What efforts have been taken to reduce the high rates of adolescent pregnancy? What steps have been taken to address early marriage and forced sex as underlying factors in the incidence of adolescent pregnancy in Uganda?
11. What measures are being taken to address the systemic problem of sexual violence and harassment in schools? Specifically, has the government taken measures to provide confidential reporting protocols to protect and encourage victims who come forward and seek legal recourse?

Addressing the Needs of Vulnerable Groups

12. How does the government plan to address the grave disparity in access to reproductive and maternal health services for women in poverty, in rural areas and in the north?
13. What measures has the government taken or does the government plan to take to address the marginalization, discrimination and violence against sex workers? What efforts have been made to improve HIV/AIDS services, counseling and prevention for sex workers as the population most vulnerable to infection? What efforts have been made to reduce violence and discrimination by the police force and healthcare sector against sex workers, and to improve access to sexual and reproductive healthcare services? Has the government taken any steps to address the marginalization and discrimination against the LGBTI and disabled communities, resulting in a lack of access to services for populations already in situations of vulnerability?

Legal Framework and Implementation of Laws and Judicial Decisions

14. Does the Parliament plan to amend the HIV and AIDS Prevention and Control Bill, 2010 to address civil society concerns and bring it into compliance with international human rights standards, including the International Guidelines on HIV/AIDS and Human Rights? Will the clauses providing for compulsory testing of pregnant women and other vulnerable persons, the criminalization of HIV transmission, and the nonconsensual disclosure of HIV-status to sexual partners be removed from the bill?
15. When does the government intend to pass the Marriage and Divorce Bill? Why has it been pending for so long?
16. How does the government plan to effectively implement the recently passed Domestic Violence Act, 2010?
17. What steps has the government taken to strengthen judicial recourse for women and girls who are victims of sexual violence, and encourage them to pursue justice without fear of impunity or retaliation by their attackers? For instance, has the government initiated measures to ensure free legal assistance, trainings for attorneys and judges to sensitize

them regarding gender discrimination and sexual violence, and benchmarks to reduce the backlogging which results in most sexual violence cases being dropped?

18. How will the government ensure effective implementation of key constitutional court decisions which protect and advance women's rights?

There remains a significant gap between the provisions of the CEDAW Convention and the reality of women's reproductive and sexual health and lives in Uganda. We hope that this information is useful during the Committee's review of Uganda's compliance with the provisions of CEDAW.

CONCLUDING OBSERVATIONS ON THE UGANDAN GOVERNMENT'S OBLIGATIONS ISSUED BY THE CEDAW COMMITTEE AND THE AFRICAN COMMISSION ON HUMAN AND PEOPLES' RIGHTS (AFRICAN COMMISSION)

Following the submission of the above shadow letter, the CEDAW Committee issued concluding observations on October 22, 2010 concerning its consideration of the Ugandan Government's report. In addition, in May 2009, the African Commission had previously issued concluding observations on Uganda's third periodic report for the period 2006-2008. A summary of the key relevant comments from both bodies, about the Ugandan Government's obligations to protect the reproductive and sexual health and rights of women and girls, is included here.

State of Maternal Health and Family Planning

The CEDAW Committee expressed its concern that "maternal mortality rates remain very high," observing that "clandestine abortions [are] a major cause thereof."²⁶⁶ The Committee also observed that teenage pregnancy rates remain very high, that access to quality reproductive and sexual health services is limited, and that "existing sex education programmes are not sufficient, and may not give enough attention to the prevention of early pregnancy and the control of STIs."²⁶⁷

The Committee called upon Uganda "to strengthen its efforts to reduce the incidence of maternal and infant mortality and to raise awareness of and increase women's access to health-care facilities and medical assistance by trained personnel, especially in rural areas."²⁶⁸ In addition, the Committee urged Uganda to increase education about, and access to, "affordable contraceptive methods;" to "ensure that women in rural areas do not face barriers in accessing family planning information and services;" and to promote "education on sexual and reproductive health and rights," particularly for adolescents.²⁶⁹

Impact of HIV/AIDS on Women and Girls

The CEDAW Committee noted "with deep concern" that Uganda still faces a "serious" HIV/AIDS epidemic and that "women and girls are disproportionately affected by HIV."²⁷⁰ The Committee specifically noted its concern that "women and girls may be particularly susceptible to infection owing to gender-specific norms and that the persistence of unequal power relations between women and men and the inferior status of women and girls may hamper their ability to negotiate safe sexual practices"²⁷¹ The Committee urged Uganda to "take continued and sustained measures to address the impact of HIV/AIDS on women and girls" and "to enhance its focus on women's empowerment . . . [and] include clearly and visibly a gender perspective in its policies and programmes on HIV/AIDS."²⁷²

Gender-Based Violence and Discrimination

The CEDAW Committee “expresse[d] its concern at the prevalence of violence against women and girls,” including “widespread domestic violence” and “the inordinately high prevalence of sexual offences against women and girls.”²⁷³ The African Commission likewise expressed concern about the prevalence of domestic violence in Uganda.²⁷⁴

The CEDAW Committee expressed its concern at “the absence of a holistic approach to the prevention and elimination of all forms of violence against women” and at “a culture of silence and impunity” that appears to legitimize violence against women in Uganda.²⁷⁵ The Committee was also troubled by the under-reporting of cases, reports of corruption in police stations, and the lack of adequate social support services for survivors of violence.²⁷⁶

The Committee further noted that internally displaced women and girls in northern Uganda, older women, and women with disabilities are particularly vulnerable to sexual and gender-based violence and abuse.²⁷⁷ The African Commission likewise observed that rape as a part of the internal armed conflict in northern Uganda is a human rights violation that “affect[s] the enjoyment of rights enshrined in the [African] Charter.”²⁷⁸ The Committee was also “seriously concerned at the high number of girls who suffer sexual abuse and harassment in schools, as well as the high number of girls who suffer sexual violence while on their way to school.”²⁷⁹

The CEDAW Committee specifically urged Uganda “to expeditiously adopt” the implementing regulations for the Domestic Violence Bill passed in 2010, “to develop a coherent and multisectoral action plan to combat violence against women,” and to adopt comprehensive legislation “criminalizing all forms of sexual violence and abuse.”²⁸⁰ The Committee also recommended “the implementation of training for the judiciary and public officials, in particular law enforcement personnel and health service providers[,] in order to ensure that they are aware of all forms of violence against women and can provide adequate gender-sensitive support to victims” and recommended “the establishment of counseling services and shelters for victims.”²⁸¹

Harmful Traditional Practices

With respect to harmful traditional practices, and in particular FGM, the CEDAW Committee “expresse[d] its concern at the continued prevalence of” FGM in Uganda despite the recent passage of the law outlawing the practice.²⁸² The African Commission likewise noted the “[t]he prevalence of harmful cultural practices[,] like the ritual sacrifice of children” and FGM,²⁸³ and specifically expressed concern that Uganda has yet to pass legislative measures “criminaliz[ing] torture and violence against children.”²⁸⁴

The CEDAW Committee called on Uganda “to ensure the effective implementation” of the 2010 law prohibiting FGM and recommended that Uganda “continue and increase its awareness-raising and education efforts” with the help of civil society and religious organizations in order to eradicate FGM and “its underlying cultural justifications.”²⁸⁵ In the Committee’s view, such educational campaigns “should include the design and implementation of effective education campaigns to combat traditional and family pressures in favour of this practice,” particularly among illiterate parents.²⁸⁶

The Committee also discussed the practice of early marriage, “express[ing] its concern at the high number of early marriages of girls”²⁸⁷ and, accordingly, called upon Uganda “to take all necessary measures to combat the practice of early marriages.”²⁸⁸ The African Commission also specifically noted its concern regarding “the continued occurrence of early marriages in Uganda”²⁸⁹ and recommended that Uganda “[u]rgently introduce laws to criminalize violence against children, early marriages and measures that will help towards the total eradication of all the harmful cultural practices in Uganda.”²⁹⁰

In addition, the CEDAW Committee was concerned that pending legislation in Uganda concerning marriage and family relations did not address existing gaps “in the laws on marriage, property rights, inheritance, divorce and the family in general.”²⁹¹ The Committee called upon Uganda “to harmonize civil, religious and customary law” with its obligations under CEDAW to eliminate discrimination against women in marriage and family relations.²⁹²

ENDNOTES

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