I. EXECUTIVE SUMMARY

1. Reproductive Health Uganda (RHU) is a non- governmental organization that is promoting Sexual and Reproductive Health and Rights (SRHR) in Uganda. It is affiliated to the International Planned Parenthood Federation (IPPF). In accordance with Human Rights Council Resolution 5/1 of June 18, 2007, RHU hereby makes its submission to the Human Rights Council for consideration.

2. The Government of Uganda (GOU) demonstrated its commitment to the reduction of maternal mortality rate, and improving access to sexual and reproductive health services, including family planning by adopting international, regional and national instruments[1] and standards. These include; the Sustainable Development Goals (SDGs), Maputo Protocol, Abuja Declaration and a number of policies and strategies such as Uganda Vision 2040, National Development Plan (2009/10-2014/15), Health Sector Strategic Plan (2010/11-2014/15), National Health Policy, Gender Policy, National Policy Guidelines and Service Standards on SRHR, Adolescent Health Policy, and Health Strategic Plans, among others.

3. Despite all the policies above, Uganda's maternal mortality ratio (MMR) is still high among the highest in the region with 435/ 100,000 live births. Access to quality maternal health services from government health facilities is still a hurdle, yet majority of the population cannot afford to pay services in private health services. This is a violation to people's SRHR.

THE KEY ISSUES

A) Inadequate Access to maternal and reproductive health services and commodities.

i. Access to maternal health services

4. According to the Uganda Demographic Health Survey (UDHS) 2011, maternal mortality is the leading cause of death among women of childbearing age in Uganda. This is as a result of major complications that account for 80% of all maternal deaths such as; severe infections (usually after childbirth), high blood pressure during pregnancy (pre-eclampsia and eclampsia) and unsafe abortion. Other contributions are as a result of systematic delays that include; delays in 1) Seeking health care by the woman, 2) Reaching the health service point 3) Receiving adequate health care[2] and negligence from health care providers, limited access to emergency obstetric care, and limited access to information on reproductive health care services, among others.

5. Treaty monitoring bodies have attributed states' failure to reduce maternal deaths to violation of a number of rights including the rights to health and life, and have tasked the state to take concrete steps to reduce the high maternal mortality rates.[3] During the previous Universal Periodic Review (UPR) of Uganda, the government accepted recommendations to continue to work towards reducing the high maternal mortality.[4] 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.[5]

6. Despite these recommendations, however, the maternal mortality rate remains relatively high. The Ministry of Health has attributed difficulties in accessing maternal health services to several factors, including a lack of human resources, medicines and supplies, weak infrastructure and weak internal communications protocols at health care facilities.[6] Even though public health care facilities provide maternal health services free of charge, they often require that women purchase supplies from outside pharmacies when there is stock-out.[7] This discourages women from seeking delivery care from heath care facilities, since they are concerned that they have to travel to the

health facility only to find out that there are no supplies. This in turn creates disparities in access based on a women's level of income and geographical location.[8]

7. Although in the previous UPR, the Human Rights Council recommended that the government raise the health budget to 15% of its national budget in order to increase access to sexual and reproductive health services,[9] the government has not implemented this recommendation and reproductive health services remain severely underfunded. The health sector budget was only about 8.6% of the total national budget in the 2013-2014 fiscal year and 9% of the 2014-2015 budget.[10] Instead of improving, the budget allocation for health has decreased to 7% of the total budget for 2015-2016 fiscal year. If the government is to achieve the goals it has committed to under the Sustainable Development Goals, including reducing the MMR to less than 70 deaths per 100,000 live births by 2020, [11] it needs to intensify its efforts of making maternal health care services more accessible including by allocating adequate resources.

ii. Unaffordable health care services in Uganda

8. In a bid to ensure that Ugandans access affordable health care services in public health facilities, the president in March 2001 abolished cost sharing in the public sector and user fees were stopped. This was influenced by a report that cost sharing was leading to unnecessary suffering and even death. This has, however, not only had positive but also negative implications to the lives and health of the people. It should not be assumed that the end of cost sharing resulted in free health care services to the patients. In other instances, informal "under the-table" payments to health workers are 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.

9. The continuous violation of the right to health and specifically the SRHR for women saw Uganda civil society organizations to petition the courts of law for government's failure to protect women

given their natural maternal functional role they play in society. The Supreme Court ordered Constitutional court to hear the matter on its merits after the State Attorney rejected to the Petition stating the Courts did not have a role to play in realizing sexual reproductive health rights as the political question doctrine/ doctrine of separation of powers barred them. Constitutional petition No. 16 of 2011 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 duty[12]

10. Although health facilities that have been cited in the petition have had greater achievements in ensuring that free services are accessed by the population, the question of whether activists will first take government to court to act remains perturbing. The situation would rather be different if the government either implemented its policy on no cost sharing or specifically stated that access to health care services has to be paid for by all. In this way, women would not die for failure to afford access health care services.

iii. Limited access to adolescents sexual and reproductive health services in Uganda

11. A number of factors impede youth and adolescents from seeking and obtaining sexual and reproductive health services. These include early sexual engagement, inadequate SRHR services and information, cultural and religious beliefs among others. Although the government is commended for establishing policies to address adolescent access to sexual and reproductive health services, including the Adolescent Health Policy Guidelines and Service Standards[13] and the National Minimum Healthcare Package,[14] implementation of these policies is yet to be realized.

12. The failure to implement adolescent Sexual and reproductive health-related policies has affected adolescents in accessing sexual reproductive health services. Such impediments include disapproval from health workers in accessing family planning services, lack of youth friendly corners within health facilities which creates a barrier to privacy and confidentiality, inadequate

supplies and providers who are not trained in providing adolescent friendly services. Indeed, adolescents in Uganda are left with misinformation and myths about sex. For example, a study revealed that 54% of young people think that a girl could not get pregnant when engaging in sex for the first time. In addition, negative societal perceptions and stigma associated with adolescent pregnancy outside the context of marriage discourage pregnant girls from seeking proper healthcare and support, driving a percentage of girls in this predicament to seek unsafe abortions.[15]

13. Bridging the gap between service delivery and implementation of the policies is important given that nearly 1 in 4 Ugandan girls age 15-19 has already given birth or is pregnant with her first child[16] 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 a affiliated rise in maternal morbidity and mortality,[17] higher HIV/AIDS rates amongst adolescents and greater drop-out rates among school-aged girls.[18]

iv. <u>Inadequate access to contraceptive information and services</u>

14. 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.

15. 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%. 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 services. Further, the use of, and access to, contraception among women also varies depending on geographical

location, level of education and income level. According to the 2011 UDHS, 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.

16. 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.

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

17. 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 refuge 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 services.[19]

18. 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

19. Questions and Recommendations

A) Questions

Key questions to the GOU include;

i. What concrete measures is the government undertaking to ensure achievement of the Sustainable Development Goal of reducing the MMR to less than 70 deaths per 100,000 live births?

ii. What steps is the government taking to implement the recommendation from the previous UPR regarding to increasing its health budget allocation to 15% of the total budget in accordance with its commitment under the Abuja Declaration?

iii. What measures is the government taking to ensure that women access free health care services within government health facilities.

B) Recommendations

Based on the discussions above, RHU hereby makes the following recommendations;

i. The state should remove all legislative barriers that prohibit young people especially unmarried young women from accessing sexual and reproductive health services, especially family planning.

ii. The state should intensify its efforts towards making maternal health services more accessible by increasing its health budget to 15 percent as per the Abuja Declaration.

iii. The Government of Uganda 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 me the demand.

[1]International 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.

[2] Annual Health sector performance report 2013/ 2014 and see also http://www.maternityworldwide.org/what-we-do/three-delays-model/

[3] Committee on Economic, Social and Cultural Rights (CESCR Committee), *CESCR Committee considers report of Uganda*: *See, e.g.*, Comm. on Econ., Soc. and Cultural Rights, Concluding Observations on the Initial Report of Uganda, ¶¶ 33-34, U.N. Doc. E/C. 12/UGA/CO/1 (June 24, 2015); Committee on the Elimination of Discrimination Against Women (CEDAW Committee), Concluding Observations: Uganda, U.N. Doc. CEDAW/C/UGA/CO/7 (2010), ¶ 36.

[4] 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

[5] 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).

[6] WHO, UGANDA (2011) 3, *available at* http://www.who.int/maternal_child_adolescent/epidemiology/profiles/ maternal/ uga.pdf. (http://www.who.int/pmnch/activities/commodities/2010_maternal_health_uganda.pdf?ua=1)

[7] Elizabeth Leahy, et. al., *Maternal Health Supplies in Uganda* 5 (2010) *available at* http://www.who.int/pmnch/activities/commodities/2010_maternal_health_uganda.pdf?ua=1

[8] WHO, UGANDA (2011) 4-6, *available at* http://www.who.int/maternal_child_adolescent/epidemiology/profiles/ maternal/ uga.pdf.

[9] Human Rights Council, *Universal Periodic Review: Uganda*, para. 112.41, U.N. Doc. A/HRC/19/16 (2011).

[10] UGANDA, NATIONAL BUDGET FRAMEWORK PAPER.

[11] SUSTAINABLE DEVELOPMENT GOALS, GOAL 3 TARGETS (2015) *available at* http://www.un.org/sustainabledevelopment/health/.

[12] http://www.cehurd.org/publications/?did=13

[13]Ministry 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.

[14]Ministry of Health; Uganda.Uganda National Health Policy. Kampala: Ministry of Health; 1999.

[15]Rutaremwa 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

[16] 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.

[17]Rutaremwa 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

[18]Rutaremwa 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

[19] [19] **http://www.ippf-sprint.org/ippf-sprint-initiative-to-provide-humanitarian-assistance-to-the-burundi-refugees-in-uganda/**