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ALTERNATIVE REPORT ON THE REPUBLIC OF UGANDA SCHEDULED TO BE REVIEWED BY THE COMMITTEE ON THE RIGHTS OF THE CHILD DURING ITS 100TH ORDINARY SESSION

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Executive Summary

1. Uganda is a state party to the United Nations Convention on the Rights of the Child (the Convention or CRC). Therefore, the Convention's provisions bind Uganda to protect, respect, fulfil, and promote children's rights in Uganda.
2. Uganda has also enshrined the right to health under National Objectives and Directive Principles of State Policy no. 14 and 20 as read with Article 8A of the Constitution of the Republic of Uganda.[1] These provisions obligate Uganda to ensure the highest attainable standard of health, including sexual and reproductive health, and ensure that all persons, including women and girls, have full and unfettered access in realising this right to reproductive health.
3. Based on the analysis of the Center for Reproductive Rights (the Center) and its partners, the Women and Rural Development Network (WORUDET) and Network for Community Development (NCD), constitutional legal, policy, and administrative measures, Uganda still needs to meet its obligations under the Convention effectively. The Center and partners have focused on select themes and issues highlighted and detailed in this alternative report. As a result, adolescents and, by extension, women and girls in the country are unable to fully access and enjoy their sexual and reproductive health and rights, in line with overarching human rights principles of dignity, equality and non-discrimination, access to information within the framework of the best interest of the child that is free from cruel and degrading treatment in line with the provisions of the Convention.
4. Whereas several laws and policies provide for sexual and reproductive rights, there still exists a distinct disconnect from law and practice, legislative, policy gaps and other structural barriers that hinder the full realisation of these rights. For example, adolescent girls struggle to access dignified maternal health care attributed to various factors, including scarcity of health facilities, the criminalisation of abortion and aftercare, the criminalisation of consensual, non-coercive, non-exploitative sexual activity among adolescents contributing to the social stigma around abortion and adolescent sexuality, and resultantly, women and teenage girls are unable to access essential reproductive health information and services.
5. Therefore, the government of Uganda needs to fully implement its obligations under the Convention, including carrying out legislative, policy, and administrative reforms to address laws that hinder the realisation of girls' rights and fully implement existing progressive laws. Further, more than legislative measures are needed to safeguard girls' rights, and the government also needs to put in place administrative, budgetary, and programmatic measures to address social and economic barriers that impede girls' enjoyment of their rights.

[1] *CEHURD and Ors v Attorney General (Constitutional Petition No.1 of 2013)*

Background and Introduction

About the Organisations

6. **The Center for Reproductive Rights (the Center)**[2] is a non-profit legal advocacy organisation dedicated to promoting and defending reproductive rights worldwide. The Center uses the power of law to advance reproductive rights as fundamental human rights around the world.
7. **Women and Rural Development Network (WORUDET)**[3] is a women's rights organisation operating in Northern Uganda to ensure that women and children are valued and reach their full potential by respecting their rights.
8. **Network for Community Development (NCD)**[4] is a non-governmental organisation that aims to improve the lives of Uganda's poor and underserved communities through capacity building, service delivery, information sharing and advocacy.
9. The Center and its partners (WORUDET AND NCD) present this alternative report, which contains information ahead of the Republic of Uganda ("Uganda") review by the UN Committee on the Convention on the Rights of the Child (the Committee) at its 100th Ordinary Session. The Center and its partners seek to contribute to the Committee's mandate by providing independent information concerning Uganda's implementation of the United Nations Convention on the Rights of the Child (CRC).
10. The report highlights select themes and issues (including factual information and jurisprudential developments) regarding sexual and Reproductive Health Rights (SRHR) in adolescent girls, provides a list of questions for consideration, and presents recommendations for the Committee to consider while reviewing Uganda's compliance with the obligations under the Convention.
11. This report highlights the following select articles and thematic issues regarding adolescent girls and the scope of Uganda's realisation of the obligations under the Convention as follows:
    a. **Article 17** (rights of the child to **access information** on Sexual and Reproductive Information and Education, **including information on contraception** and **consent to services)**
    b. **Article 19** (protection of the child from physical or mental violence, injury, abuse, neglect, maltreatment or exploitation) and on lack of **access to dignified maternal health care for young adolescents and criminalisation of consensual non-exploitative sexual conduct**
    c. **Article 24** (right of the child to the highest attainable standard of health care with an emphasis on sexual and reproductive rights standard of health care citing the lack of **access to safe and legal abortion care**
12. This alternative report supplements the report submitted by the government of Uganda and elaborates on information primarily derived from the foregoing select articles.

[2] https://reproductiverights.org/about-us/;
[3] https://worudet.net/;
[4] https://ncduganda.org/;

Substantive Themes and Issues

A. Articles 17- the rights of the child to access information, including information on contraception and consent to services

i. Legal and Policy Framework on Access to Information and Education

13. The Constitution of Uganda recognises the right to access information. Article 41 provides that: "*Every citizen has a right of access to information in the possession of the State or any other organ or agency of the State except where the release of the information is likely to prejudice the security or sovereignty of the State or interfere with the right to the privacy of any other person*".[5] Additionally, Article 30 provides a general right to education for all citizens. Together, these constitutional rights empower citizens in Uganda to access information held by the state and to have it delivered to them to further their education. It follows that women and adolescent girls should be able to receive the information that the government holds concerning their sexual and reproductive health.

14. Further, the Constitution poses additional obligations on the government to provide education to children via Article 34 (2), which states: "*A child is entitled to basic education which shall be the responsibility of the State and the parents of the child.*"[6] Although the Constitution does not explicitly define a child's age, Article 10(3)(a) of the education (pre-primary, primary and post-primary) Act of 2008 states that "primary education shall be universal and compulsory for pupils aged 6 (six) years and above, *which shall last seven years*".[7] Therefore, the state guarantees adolescent girls' education until age 13.

15. Additionally, Article 4 of Uganda's Children (Amendment) Act 2016 provides for the right of a Child to include (i) access to information that a parent, guardian or other person in authority deems critical to the child's well-being (Article 4 (c)); (ii) safety, privacy, information and access to basic social services (Article 4 (g)); and (iii) right to use any social amenities or other resources available in any situation of armed conflict or natural or man-made disasters (Article 4 (I)). Also, Section 4 (1) and (2) of the Education (Pre-primary, primary and post-primary) Act 2008 provides that the education and training of a child shall be the joint responsibility of the state, the parent or guardian and other stakeholders. – and basic education shall be provided and enjoyed as a right by all persons.[8]

16. In 2016, the government issued a ban on a comprehensive sexuality education program in school and non-school settings.[9] The ban came as a response to the public outcry over claims that children in the Kampala region were being taught "homosexuality" and masturbation through the curriculum. The curriculum in question was developed in 2003 by Butterfly Works and the World

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5 Constitution, Article 41.

6 *CEHURD v. Attorney General & Family Life Network* [Miscellaneous Cause No. 309 of 2016].

7 Education (Pre-Primary, Primary and Post-Primary) Act, 2008 on 29 August 2008

8 Children Act. Section 4(1)-(2).

9 Parliamentary Ban on the 16th August 2016; Moore, E.V., Hirsch, J.S., Spindler, E. et al., *Debating Sex and Sovereignty: Uganda's New National Sexuality Education Policy*, 2022, Sexuality Research and Social Policy. https://doi.org/10.1007/s13178-021-00584-9, p. 683.

Population Foundation in collaboration with a national organisation, SchoolNet Uganda.[10] When the Minister of Gender officially banned sex education in 2016, she cited "*the likely dangers of having the (sex education) training infiltrated with the dangerous vices that are inconsistent with the national values, norms and morality.*" [11]

17. Perhaps in response to such outcry, the Ministry of Education and Sports (the "MoES") adopted the National Sexuality Education Framework 2018 (the "NSE Framework"). The Minister of Education described the NSE as "*home-grown…developed in line with existing national policies and commitments*." [12] The NSE's emphasis on defending national values makes Uganda fall short of meeting the obligations under the Constitution. This is because the NSE prohibits full access to comprehensive information on sexual and reproductive health to women and, crucially, adolescents who need this information at a critical formative stage of their lives. Furthermore, the NSE Framework is problematic due to its religious underpinnings and lack of a culturally sensitive approach to sexual and reproductive information and sexuality education:

18. *Lack of information on prevention of pregnancy and transmission of STIs*: The NSE Framework is centred on virginity and abstinence, associating these concepts with purity and morality,[13] implying that adolescents who engage in sex are impure and immoral. This approach, however, perpetuates existing taboos surrounding adolescent sexual health that already hinder adolescents' access to sexual and reproductive health information and services.[14] The NSE framework primarily advocates abstinence as the key method for pregnancy prevention and protection against sexually transmitted diseases.[15] Further, it does not require that adolescents be taught about the other methods of pregnancy prevention and protection from STIs until they are 13 years old. Even for adolescents between 13–19, the framework does not mention the specific methods they should be taught about.[16] This NSE Framework was adopted despite existing evidence, including from the UDHS, that 7–13% of adolescents aged 10–14 years are sexually active, and 50–55% of adolescents are sexually active by age 18.[17] Thus, the sexuality curriculum fails to provide for adolescents to receive timely, comprehensive and non-judgmental information that addresses their realities and their sexual and reproductive health needs.

19. Moreover, while the NSE Framework had evident lacunas in the information delivered to adolescent girls, Uganda also failed to provide an educational framework on sexual and

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10 Daily Monitor, 'At least 100 schools tricked into teaching homosexuality', 2016, May 7, available at https://www.monitor.co.ug/News/Education/At-least-100-schools-tricked-into-teaching-homosexuality/688336-3192576-format-xhtml-14ylcct/index.html.

11 Moore, E.V., Hirsch, J.S., Spindler, E. et al., *Debating Sex and Sovereignty: Uganda's New National Sexuality Education Policy*, 2022, Sexuality Research and Social Policy. https://doi.org/10.1007/s13178-021-00584-9, p. 683.

12 Id.

13 Ministry of Education and Sports, *National Sexuality Education Framework*, pp. 21, 30, 36.

14 Chidwick H, Baumann A et al., *Exploring Adolescent Engagement in Sexual and Reproductive Health Research in Uganda, Rwanda, Tanzania, and Uganda: A Scoping Review*, 2022, PLOS Global Public Health. https://journals.plos.org/globalpublichealth/article?id=10.1371/journal.pgph.0000208, p. 4; McGranahan M., Bruno-McClung E. et al., *Realising Sexual and Reproductive Health and Rights of Adolescent Girls and Young Women Living in Slums in Uganda: A Qualitative Study*, 2021, Reproductive Health. https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-021-01174-z, p. 9.

15 Ministry of Education and Sports, *National Sexuality Education Framework 2018*, pp. 20-39.

16 Ibid, pp. 32-33, 38-39.

17 UDHS 2016, Table 4.5, p. 80; Kemigisha E., Bruce K. et al., *Sexual health of very young adolescents in South-western Uganda: a cross-sectional assessment of sexual knowledge and behaviour*, 2018, Reproductive Health Journal.

reproductive health for out-of-school adolescents despite the high dropout rate. Notably, 38% of children do not reach the final level of primary school, and only 30% of children who join secondary school sit their final exam.[18] Therefore, despite the constitutional impetus, the government of Uganda has been inconsistent in its approach to ensuring access for women and adolescents to sexual and reproductive information and education. There is now a pressing need for the government to develop an out-of-school framework for delivering comprehensive sexual and reproductive health education.

Jurisprudential Landscape

20. In 2021, the *Center for Health, Human Rights and Development ("CEHURD") v. Attorney General and Family Life Network*, a court, recognised that the Ugandan Government has an obligation to develop a comprehensive sexuality education program. The CEHURD brought the case for judicial review seeking (i) a declaration that the "*inordinate delay and omission by the Ministry of Education and Sports … to issue a policy on comprehensive sexuality education*" violates the Constitution; (ii) an order to quash the Parliamentary ban on comprehensive sexuality education materials; and (iii) an order that the Ministry of Education and Sports (the "MoEaS") "*comes up with a policy on comprehensive sexuality education"*.[19]

21. The High Court of Uganda at Kampala (Civil Division) (the "High Court") interpreted the right to access information under Article 41 to broadly include the right to sexual education and information in the light of firmly established international conventions to which Uganda is a state party. The High Court held that "*read together with the international law and jurisprudence on sexuality education and comprehensive sexuality education, Article 41 of the constitution (among others) […] would be violated if there existed a void in terms of the education needs of our nation's children*".[20]

22. The High Court went on to State that Uganda is a party to international conventions and bodies, such as the UN Committee on the Rights of the Child[21] and the UN Convention on the Elimination of Discrimination against Women,[22] which "*unequivocally require the government to enact a policy that comprehensively provides for sexuality education.*"[23]

23. The High Court found "*no justification*" for Uganda's behaviour, emphasising that "*the inordinate delay and/or omission of over ten years to develop a comprehensive sexuality education policy in Uganda is a violation of Uganda's obligations under international law […] and Articles 30, 41 and*

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18 United Nations Children's Fund and Ministry of Gender, Labour and Social Development, *Situation Analysis of Children In Uganda – 2019*, p. 8.

19 *Id.*

20 *CEHURD v. Attorney General & Family Life Network* [Miscellaneous Cause No. 309 of 2016].

21 See paragraph. 22 of the UN Committee on the Rights of the Child General comment No. 4 (2003): "Adolescents have the right to access adequate information essential for their health and development and for their ability to participate meaningfully in society. It is an obligation of State parties to ensure that all adolescent girls and boys, both in and out of school, are provided with, and not denied, accurate and appropriate information on how to protect their health and development and practice healthy behaviours. This should include information on the use and abuse of tobacco, alcohol and other substances, safe and respectful social and sexual behaviours, diet and physical activity."

22 UN General Assembly, Convention on the Elimination of All Forms of Discrimination Against Women, 18 December 1979, United Nations, Treaty Series, vol. 1249, p. 13, http://www.un.org/womenwatch/daw/cedaw/cedaw.htm.

23 *CEHURD v. Attorney General & Family Life Network* [Miscellaneous Cause No. 309 of 2016], paragraph 20.

34(2) of the Constitution; sections 4(1) (c), (g) and (i) of the Children (Amendment) Act 2016; section 4 (1) (2) of the Education (pre-primary, primary and post-primary) Act 2008." Accordingly, the High Court directed the MoEaS to "*develop a comprehensive sexuality education policy*" which "*must be completed within two years, with the ministry reporting on progress to the registrar of this court every six months.*" [24]

24. Therefore, the High Court provided an unequivocal impetus for the government to create an appropriate policy framework and sexual education program in accordance with its obligations in the Constitution and international treaties. However, Uganda has failed to develop an appropriate policy framework nearly a decade after the petitioners first submitted their claim and three years after the judgement was released.

Factual background

25. Uganda faces one of the highest adolescent pregnancy rates in sub-Saharan Africa. The UDHS reveals that 25% of adolescent girls have had their first child by age 19.[25] Despite initial increases recorded between 2017 and 2018 (6.4%), subsequent years saw a decline of 2.1% (2018 to 2019) and 0.9% (2019-2020).

26. The 2022 Continental study findings of the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) in collaboration with the Center, Africa Child Policy Forum and Plan International titled, "***Teenage Pregnancy in Africa; Status Progress and Challenges"***[26] This trend is consistent with that in Uganda, where several case studies were sampled. The report concludes that teenage pregnancy has a prevalence rate of more than 25% in 24 African countries, with an estimate that one in every five adolescent girls in Africa becomes pregnant before reaching the age of 19. Teenage pregnancy affects girls of all backgrounds and in every part of the world, but girls from African countries are at greater risk due to factors such as poverty, low levels of education, economic status, family and community attitudes, and lack of access to reproductive health services and information.[27]

27. Additionally, inadequate access to sexual and reproductive information and education contributes to the low rates of modern contraceptive use, measuring at 9.4% among adolescent girls aged 15–19 years and 28.3% among women aged 20–24 years.[28]

28. The prevailing lack of understanding among adolescents about their bodies, menstruation, sex and prevention of pregnancy is evident. A study on the factors associated with the high prevalence of teenage pregnancy in the Kibuku District (reported at 35.8%) revealed common misconceptions among adolescent girls (aged 15 to 19 years), namely that (i) they could only get pregnant after the age of 14, and (ii) they could not (or were not sure if they could) get pregnant on their first sexual

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24 Ibid., paragraphs 20-22.

25 Cross-Sectional Study Based on Data from the Uganda Demographic and Health Survey (2016), Table 7.3, p. 120; Sserwanja Q, Musaba MW, Mukunya D., *Prevalence and factors associated with modern contraceptives utilization among female adolescents in Uganda*, 2021, BMC Women's Health, 21(1):61. doi: 10.1186/s12905-021-01206-7. https://bmcwomenshealth.biomedcentral.com/articles/10.1186/s12905-021-01206-7, p. 2.

26 Available on https://www.acerwc.africa/en/resources/publications/study-teenage-pregnancy- africa-status-progress-and-challenges or https://reproductiverights.org/acerwc-report-teenage-pregnancy-africa/;

27 Ibid pg. 4

28 UDHS 2016, Table 7.3, p. 120.

encounter.[29] Given these challenges, it is imperative for Uganda to invest in a robust policy framework to ensure accurate, comprehensive information and education for the well-being of women and adolescent girls.

Challenges

29. The lack of access to an accurate and comprehensive educational framework on sexual and reproductive health is compounded by limited reliable sources, including parents, guardians and healthcare providers.[30] Adolescent girls often receive basic sexual and reproductive health information only after experiencing an unplanned pregnancy.[31]

30. Consequently, adolescents resort to obtaining information from peers, the internet and traditional media, with these informal sources lacking an obligation to provide accurate and comprehensive scientific information, leaving adolescent girls with potentially inaccurate and harmful information.[32] Therefore, there is a critical need for the government to (i) develop a comprehensive sexual health education framework for both in-school and out-of-school adolescents and (ii) address the shortcomings identified in the current NSE Framework.

31. Despite Constitutional provisions recognising the right to information and education, the government's inconsistent approach has perpetuated the problem. The landmark *CEHURD* case prompted the High Court to mandate the development of a comprehensive sexuality education policy within two years, emphasising the government's obligation under international law and Constitutional provisions. However, the adoption of the NSE Framework, while the case was being heard, fell short of these obligations, introducing religious underpinnings and insufficient coverage of pregnancy prevention and STI transmission. The lacunas in both in-school and out-of-school frameworks and limited reliable sources for adolescents exacerbate the challenges.

ii. Legal and Policy Framework on Access to Contraception

32. With regards to adolescent girls' access to contraception, the Constitution sets the age of consent at 18 years, as it considers a "*child*" any person under the age of 18 years, restricting adolescent girls' access to modern contraceptive methods until they reach this age.[33] Nevertheless, Uganda has put in place policies that elaborate on the right to sexual and reproductive health rights, including access to contraception, for women over 18. Recognising the urgency to address concerns

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29 Manzi F., Ogwang J. et al., *Factors Associated with Teenage Pregnancy and its Effects in Kibuku Town Council, Kibuku District, Eastern Uganda: A Cross Sectional Study, 2018,* Primary Health Care, available at https://www.iomcworld.org/open-access/factors-associated-with-teenage-pregnancy-and-its-effects-in-kibukutown-council-kibuku-district-eastern-uganda-a-cross-sectional-s-2167-1079-1000298.pdf, p. 4.

30 Apolot R., Tetui M. et al., *Maternal health challenges experienced by adolescents; could community score cards address them? A case study of Kibuku District – Uganda*, 2020, International Journal for Equity in Health, available at https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-020-01267-4, p. 2.

31 Id.

32 Chidwick H, Baumann A et al., *Exploring Adolescent Engagement in Sexual and Reproductive Health Research in Uganda, Rwanda, Tanzania, and Uganda: A Scoping Review*, 2022,PLOS Global Public Health, available at https://journals.plos.org/globalpublichealth/article?id=10.1371/journal.pgph.0000208, p. 4; Muhwezi W., Katahoire A. et al., *Perceptions and experiences of adolescents, parents and school administrators regarding adolescent-parent communication on sexual and reproductive health issues in urban and rural Uganda*,2015, Reproductive Health, available at https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-015-0099-3, p. 1.

33 Constitution, Article 257.

related to total fertility, maternal mortality and adolescent pregnancies, the Ugandan Ministry of Health ("MoH") introduced the Family Planning Costed Implementation Plan, 2015–2020 ("FP-CIP"). This national strategy aimed to enhance awareness and comprehensive access to family planning interventions. The FP-CIP highlighted the importance of the "availability of a reliable supply of high-quality contraceptives, which *is essential to ensuring that FP demand is met at all levels.*"[34] In 2022, the MoH reaffirmed the significance of "*meeting women's contraceptive needs*" as a "*critical strategy to help women avoid unintended pregnancies.*"[35]

33. Notwithstanding the commendable policy efforts, there is a pressing need for progress to improve access to contraceptives for adolescent girls. This is particularly crucial given the Constitutional restriction on underage girls' access to contraceptives, the concerning population statistics discussed below and supply chain challenges exacerbated by the COVID-19 pandemic. Uganda's policymakers' acknowledgement of the issue is a positive step, but concerted actions are necessary to address the barriers and ensure the effective implementation of family planning strategies.

Factual background

34. Research shows that adolescent girls engage in sexual activity without adequate access to contraception. One in five girls initiates sexual activity before the age of 15, with 60% engaging in sexual intercourse before turning 18, the legal age to access contraceptives without parental or third-party consent.[36] Further, one in four adolescent girls aged 15–19 are already mothers or pregnant with their first child.[37] This phenomenon contributes to 18% of annual births in Uganda being attributed to adolescent childbearing.[38] Notably, half of the reported adolescent pregnancies are unintended, and 15% of them result in induced abortion.[39]

35. Despite the early initiation of sexual activity and young motherhood, 32% of sexually active unmarried women and 28% of sexually active married women have unmet family planning needs.[40] Similarly, 30.4% of all adolescents in Uganda still have unmet family planning needs.[41] Addressing these challenges is crucial, emphasising the importance of change in the law to allow girls under the age of 18 access to contraceptives without parental or third-party consent and increasing the availability of modern contraceptives (such as injectables, intrauterine devices, contraceptive pills, implants and condoms) for adolescent girls.

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34 Ministry of Health, *Uganda Family Planning Costed Implementation Plan, 2015–2020*, November 2014, p. 13.

35 Ministry of Health, *Reproductive, maternal, newborn, child, adolescent and healthy aging: sharpened plan II, 2022/23–2027/28*, July 2022, p. 12.

36 *Id.*

37 UDHS 2016, p. 94.

38 UNFPA and National Planning Authority, *Cost of Inaction: The Economic and Social Burden of Teenage Pregnancy in Uganda*, May 2022), available at https://uganda.unfpa.org/en/publications/cost-inaction-economic-and-social-burden-teenage-pregnancy-uganda, p. 20.

39 Sully E., Atuyambe L. et al., *Estimating Abortion Incidence Among Adolescents and Differences in Postabortion Care by Age: A Cross-Sectional Study of Postabortion Care Patients in Uganda*, 2018, Contraception, 98(6), doi: 10.1016/j.contraception.2018.07.135. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6219390/, p. 6.

40 UDHS 2016, p.111.

41 UNFPA, *Fact Sheet On Teenage Pregnancy, 2021*, p. 1.

36. According to the findings of the UDHS, the utilisation of modern contraceptives [42] among adolescents in Uganda remains extremely low, with only 20.9% of boys and girls aged 15–19 using such methods.[43] A more recent cross-sectional study indicates an even lower figure, revealing that merely 9.4% of adolescent girls aged 15–19 years in Uganda are using modern contraceptives and 28.3% among women aged 20–24 years.[44] These current estimates can help to understand how the lack of access to contraceptives can result in a significant unmet need, leading to unwanted pregnancies, adverse health outcomes and exacerbated inequalities.

Challenges

37. Uganda has recognised the necessity of providing adolescent girls with access to contraceptives; however, it has consistently stayed with proposals aimed at reducing the age restrictions. In 2017, the government suspended the launch of the National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights. Despite recognising that "*all women of reproductive age who desire to use* [combined oral contraceptives]" should be able to.[45] The guidelines were stalled due to concerns about the "*appropriate age for family planning commodities.*"[46] The state minister for primary healthcare noted that it was important to emphasise abstinence for young people.[47] This reflects outdated views on family planning and fails to recognise the realities of adolescents engaging in sexual activities, as discussed above. It further undermines the progress of addressing Uganda's unmet family planning needs among adolescents.

38. Adolescent girls below the Constitutional age of consent are required to seek third-party or parental authorisation to access contraception. The FIP-CIP recognised that it was challenging for sexually active youth to access family planning services.[48] However, it failed to address the elimination of third-party/parental authorisation concerning adolescent contraception. Research indicates that 38% of healthcare providers, both in private and public institutions, refuse to provide contraceptive services to individuals under 18 without consent from a parent or spouse.[49] The lack of clarity in law and policy on the requirements and limitations for accessing contraceptives hinders adolescent

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42 The Word Health Organisation considers modern methods of contraception as: oral contraceptive pills, implants, injectables, contraceptive patch and vaginal ring, intrauterine device (IDU), female and male condoms, female and male sterilization, vaginal barrier methods (including the diaphragm, cervical cap and spermicidal agents), lactational amenorrhea method (LAM), emergency contraception pills, standard days method (SDM), basal body temperature (BBT) method, TwoDay method and sympto-thermal method.

43 Ministry of Health, *National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights* (4th edn, August 2017), p. 1.

44 Cross-Sectional Study Based on Data from the Uganda Demographic and Health Survey (2016), Table 7.3, p. 120; Sserwanja Q, Musaba MW, Mukunya D., *Prevalence and factors associated with modern contraceptives utilization among female adolescents in Uganda*, 2021, BMC Women's Health, 21(1):61. doi: 10.1186/s12905-021-01206-7. https://bmcwomenshealth.biomedcentral.com/articles/10.1186/s12905-021-01206-7, p. 3.

45 Ministry of Health, *National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights* (4th edn, August 2017), p. 113.

46 Advanced Family Planning, 'Uganda Government Suspends Launch of Sexual and Reproductive Health and Rights National Guidelines and Service Standards', available at https://www.advancefamilyplanning.org/uganda-government-suspends-launch-sexual-and-reproductive-health-and-rights-national-guidelines-and.

47 Id.

48 Ministry of Health, *Uganda 2014: Uganda Family Planning Costed Implementation Plan, 2015–2020*, November 2014, p. 13.

49 Nalwadda G., Mirembe F. et al., *Constraints and Prospects for Contraceptive Service Provision to Young People in Uganda: Providers' Perspectives*, 2011, BMC Women's Health Journal, available at https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-11-220, p. 5.

girls from obtaining healthcare services, such as contraceptives, even when reaching health facilities.

39. Furthermore, economic and geographic barriers pose significant challenges to accessing contraceptives for women of all ages in Uganda. Those residing in rural communities face higher indirect costs, such as travel costs, to reach urban areas with more concentrated health facilities. The scarcity of funding and resources in Uganda's healthcare system further exacerbates the issue as women attempting to access contraceptives at local clinics may face obstacles, compelling them to travel to urban areas or other distant clinics.[50] This imposes economic strain and psychological stress, especially when seeking emergency services requiring swift action within a 72-hour.

iii. Legal and Policy Framework on Consent to Services and Information

40. According to the Constitution, individuals are deemed to have the capacity to make their own decisions only at the age of 18 years. Although it is important that adolescents, including adolescent girls, have parents and/or guardians who contribute and assist in their development, the CRC provides that many adolescents are sufficiently mature and emancipated before the age of 18 not to require parental or third-party consent to access sexual and reproductive services and information. Their evolving capacities should be recognised.

41. The existing legal landscape in Uganda presents contradictions regarding the age at which adolescent girls can be provided consent, creating confusion and impeding access to crucial sexual and reproductive health services. For example, the prescribed age for when an individual can consent to marriage in Uganda varies throughout the various domestic legislation, from age 16 to age 21[51] This calls for necessary legal review and reform to create consistency. In doing so, Uganda should be guided by the obligations enshrined in the CRC, which emphasises the right of the child to freely express their views in matters affecting them, with due consideration given to the child's age and maturity.[52] Legal reforms should ensure consistency and respect girls' evolving capabilities.

Thus, the Center and its partners respectfully urge the Committee to pose the following questions to the Government of Uganda;

a) What measures are being put in place to develop an educational framework on sexual and reproductive health for both in-school and out-of-school adolescents?
b) What measures are being implemented to provide consistent access to sexual and reproductive health information and education to adolescents?
c) What measures are being implemented to address the shortcomings identified in the current National Sexuality Education Framework?

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50 Potasse, M.A., Yaya, S., *Understanding perceived access barriers to contraception through an African feminist lens: a qualitative study in Uganda*, 2021, BMC Public Health 21, available at https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-021-10315-9, p. 2.

51 The age varies from 16 years in the Customary Marriage (Registrations) Act, Cap 248 (Sec. 11), to 18 years in the Constitution (Art. 31(1)), to 21 years in the Marriage Act Cap 251 (Secs. 17, 19).

52 CRC. Article 12.

We also request that the Committee consider making the following recommendation to the Government of Uganda:

a) *The Government of Uganda should reinstate the 2017 National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights*.

B. **Article 19** -Lack of Access to Dignified Maternal Health Care for young adolescents and criminalisation of consensual non-exploitative sexual conduct

i. Legal and Policy Framework on Lack of Access to Dignified Maternal Health Care

42. Access to maternal healthcare is addressed in Uganda's international obligations. For instance, under the International Covenant on Economic, Social and Cultural Rights **(ICESCR**), Uganda should respect, protect and fulfil the right to health,[53] of which the right to sexual and reproductive health is an "*integral part*."[54] Further, the International Covenant on Civil and Political Rights ("**ICCPR**") mandates the promotion of better maternal healthcare.[55] The Human Rights Committee has stated that Article 6 of the ICCPR (focusing on the right to life), "*although State parties may adopt measures designed to regulate voluntary terminations of pregnancy, such measures must not result in violation of the right to life of a pregnant woman or girl, or other rights under the Covenant.*"[56]

43. Uganda's obligations in respect of the right to health require the government to (i) implement policies that improve access to maternal healthcare, (ii) repeal laws and policies that create barriers to sexual and reproductive health services, and ensure that third parties do not create barriers to such access; and (iii) adopt measures to ensure the realisation of the right to maternal healthcare.[57]

Jurisprudential Landscape

44. The Center for Health, Human Rights and Development ("CEHURD"), alongside other civil society organisations, challenged Uganda's actions and omissions concerning providing maternal healthcare. In *CEHURD and others v. Attorney General*, the petitioners argued that Uganda's actions were inconsistent with the right to health recognised by Uganda in the Constitution and in the international conventions in which Uganda is a state party. Specifically, the petitioners argued that Uganda failed to provide Minimum Maternal Health Services, including non-provision of basic indispensable maternal health facilities, inadequate number of midwives and doctors to provide

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53 Committee on Economic, Social and Cultural Rights, General Comment 22 (2016) on the right to sexual and reproductive health (Article 12 of the International Covenant on Economic, Social and Cultural Rights (May 2, 2016), E/C.12/GC/22, paragraph 29; General Comment 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), August 11, 2000, E/C.12/2000/4, paragraph 33.

54 Committee on Economic, Social and Cultural Rights, General Comment 22 (2016) on the right to sexual and reproductive health (Article 12 of the International Covenant on Economic, Social and Cultural Rights (May 2, 2016), E/C.12/GC/22, paragraph 1.

55 UN General Assembly, *International Covenant on Civil and Political Rights*, United Nations, Treaty Series, vol. 999, 16 December 1966, p. 171.

56 Human Right Committee, General Comment 36 (2018) on Article 6 of the ICCPR, paragraph 8.

57 Committee on Economic, Social and Cultural Rights, General Comment 22 (2016) on the right to sexual and reproductive health (Article 12 of the International Covenant on Economic, Social and Cultural Rights (May 2, 2016), E/C.12/GC/22, General Comment, paragraphs 40-45.

maternal health services, insufficient budget allocation to the maternal health sector, frequent stockouts of essential drugs, lack of emergency obstetric services at health facilities, non-supervision of public health facilities and the unethical behaviour of health workers towards expectant mothers which are said to have led to the deaths of women during childbirth.

47. The petitioners prevailed, with the Ugandan Constitutional Court (the "Court") recognising that:

> [t]he right to health of a woman forms part of her right to life, right to equality, right against torture, cruel degrading and inhuman treatment. As a fundamental right, women's right to health should be made available and accessible by the state by formulating necessary laws and programs. In the absence of any mechanisms, these rights become ineffective and would constitute a breach of obligations vested upon the state.[58]

45. The Court emphasised the "*deplorable*" state of healthcare in Uganda, especially concerning maternal healthcare, where inadequate facilities and personnel endanger women's lives. This situation was deemed a violation of the right to life as protected by Article 22 of the Constitution[59], reflecting similar decisions from other jurisdictions that were acknowledged, with approval, in Uganda. The Court urged the government to (i) dedicate focus "*to ensure that drugs destined for Government health facilities are indeed delivered and available for patients in the facilities*"[60] and (ii) "*prioritise and provide sufficient funds in the national budget for maternal health care*" within the next financial year "*to meet the constitutional obligation of the state to uphold the rights of women and fulfill their reproductive rights*."[61]

46. In July 2022, the MoH issued the Reproductive, Maternal, Newborn, Child, Adolescent and Healthy Aging Sharpened Plan for Uganda (2022/23–2027/28) (the "Sharpened Plan").[62] The Sharpened Plan outlines a national and subnational framework that aims at achieving the objectives of ending preventable maternal, newborn, child, and adolescent deaths while safeguarding the health and development of all children, adolescents, and women. It aims to deliver appropriate care, support, and information to women and adolescent girls.

Factual background

47. The latest UDHS in 2016 estimates that the maternal mortality rate in Uganda is 336 deaths per 100,000 live births[63]—five times higher than the SDG 3.1 target of 70 deaths per 100,000 births. Adolescent girls aged 15–19 are disproportionately affected, constituting 17.2% of maternal deaths, as reported by UNFPA in 2021.[64]

48. The Annual Maternal and Perinatal Death Survey for the fiscal year 2020/2021, published by the Uganda National Institute of Public Health, identified that the three major causes of institutional maternal deaths are haemorrhage, abortion complications and hypertensive disorders of

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58 *CEHURD and others v. Attorney General* [2020], paragraph 30.

59 See Section D, p. [8]

60 See Section D, Page [8]

60 *CEHURD and others v. Attorney General* [2020], paragraph 25.

61 Ibid., paragraph 47.

62 Ministry of Health, *Reproductive, maternal, newborn, child, adolescent and healthy aging: sharpened plan II, 2022/23–2027/28*, July 2022.

63 UDHS. p. 308.

64 UNFPA Uganda, *Fact Sheet on Teenage* Pregnancy, 2021, available at https://uganda.unfpa.org/sites/default/files/pub-pdf/teenpregnancy_factsheet_3.pdf, p. 1.

pregnancy.[65] Further attributing circumstances include late and critical referrals and delays in accessing essential interventions, such as caesarean sections and magnesium sulphate treatments, at referral sites, to which 60% of the maternal deaths in health facilities are attributed. The statistics demonstrate inefficiencies and inadequacies in the current maternal healthcare system.

Challenges

49. In response to the Court's directions in *CEHURD and others v. Attorney General*, the government initiated measures, such as (i) the Sharpened Plan[66] and (ii) the 2022/2023 National Budget, where the government allocated funds to upgrade rural health centres and construct new health centres.[67] Notwithstanding these efforts, there are still critical structural issues that inhibit women and adolescents from accessing high-quality maternal healthcare.

50. Healthcare facilities in Uganda (mainly middle and smaller facilities in rural areas) face shortages of essential supplies and medications, adversely affecting the quality of maternal healthcare services. These structural challenges have compelled healthcare workers to ask women and mothers to procure their medical equipment, affecting the quality of care and exacerbating barriers to healthcare.[68] The Sharpened Plan aims to augment the government budget to address the provision of maternal health equipment. The government has estimated a US$ 2.0 billion commitment to implementing the plan and asks stakeholders to contribute to the predicted funding gap of US$0.7 billion.[69] It can be anticipated that this initiative will sufficiently tackle scarcity issues.

51. Geographical accessibility issues further hinder appropriate maternal healthcare. This challenge arises from the disparity among medical facilities' capacity to handle deliveries. Consequently, women and adolescent girls are often forced to deliver in health facilities ill-equipped to provide intrapartum care. In one instance, the nearest clinic was 6 km away, and the closest hospital was 30 km away, so pregnant girls could not walk to these health facilities. Also, the only reliable mode of transportation is by motorbike, which many women need to find the money to pay for transportation to the health facility.

52. Notably, even better-equipped medical facilities (referred to as health centre III and IV facilities by the MoH) face a shortage of doctors and nurses for emergency obstetric care, and the present staff are forced to work 10–12-hour shifts. In the case of midwives, a single midwife in Uganda conducts between 350 and 500 deliveries per year, more than twice the 175 deliveries recommended by the World Health Organization.[70] Uganda's healthcare financing and budgetary limitations pose significant challenges to providing maternal healthcare services. Policymakers should explore more efficient resource allocation strategies to ensure that women and adolescent girls residing in rural communities have access to appropriate maternal healthcare.

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65 Uganda National Institute of Public Health, *Maternal and Perinatal Death Surveillance and Response (MPDSR) Report for Uganda for the Fiscal Year 2020/2021*, p. 2.

66 Id.

67 Matia Kasaija, *Final Year 2022/2023 Uganda National Budget Speech*, June 2023

68 Munabi-Babigumira S., Glenton C., Willcox M., Nabudere H., *Ugandan Health Workers' and Mothers' Views and Experiences of the Quality of Maternity Care and Use of Informal Solutions – Qualitative Study*, 2019, doi: 10.1371/journal.pone.0213511. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0213511, p. 8.

69 Ministry of Health, *Reproductive, maternal, newborn, child, adolescent and healthy aging: sharpened plan II, 2022/23–2027/28*, July 2022, V.

70 UNFPA, *Midwifery Services in Uganda*, Issue Brief 02, April, 2017, p. 4.

53. Further, women in Uganda face human rights violations, including Article 7 of the ICCPR[71] and Article 16 of the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, which provide that no one shall be subject to inhuman and degrading treatment. As previously noted by the Center, in the context of accessing maternal healthcare, women and adolescent girls reported abuse and mistreatment by healthcare providers, such as verbal abuse and neglect, during the pivotal moments of labour and delivery.[72] These experiences led women to prefer delivering at home alone or with the help of traditional birth attendants who lack the expertise and equipment to provide skilled care, especially where complications arise.[73] Overall, it is shown to have created mistrust, inequity of care and negative experiences in the maternal healthcare system.

54. Adolescent girls face additional mistreatment, which also can be considered as amounting to inhumane and degrading treatment under the ICCPR. The mistreatment of women is exacerbated for adolescent girls due to negative social attitudes towards adolescent sexuality. This often leads to abuse, use of inappropriate language (including condemning language) and ridicule for being pregnant while young and/or unmarried.[74] These experiences lead adolescent girls to refrain from seeking the medical attention they require.

55. Additionally, even at Health Centre III and IV facilities, there is often a lack of doctors and nurses to provide emergency obstetric care and the staff who are present are forced to work 10–12-hour shifts in a bid to ensure 24-hour care even though they are facing staff shortages. In the case of midwives, a single midwife in Uganda conducts between 350 and 500 deliveries per year, more than twice the 175 deliveries recommended by the World Health Organization.[75] Furthermore, health workers' absenteeism, especially on weekends and public holidays, is a common practice that leads to a lack of access to maternal health.[76]

56. The lack of healthcare personnel, equipment and commodities is further compounded by the abuse and mistreatment of women and girls, especially during labor and delivery. Women report being neglected or being subjected to physical and verbal abuse. Neglect based on income was a shared experience such that poor women often experienced delays in care or were denied care altogether because of their inability to pay. These experiences led women to prefer delivering at home alone

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71 International Covenant on Civil and Political Rights (adopted 19 December 1966, entered into force 23 March 1976) 999 UNTS 171, Article 7.

72 CRR, Supplementary Information On The Republic Of Uganda Scheduled To Be Reviewed By The United Nations Committee Against Torture During Its 75th Session, Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 2022.

73 Dantas J., Singh D. et al., *Factors affecting utilization of health facilities for labour and childbirth: a case study from rural Uganda*, 2020, BMC Pregnancy and Childbirth; Munabi-Babigumira S., Glenton C., Willcox M., Nabudere H., Ugandan Health Workers' and Mothers' Views and Experiences of the Quality of Maternity Care and Use of Informal Solutions – Qualitative Study, 2019, doi: 10.1371/journal.pone.0213511. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0213511.

74 Center for Reproductive Rights, *Facing Uganda's Law on Abortion, Experiences from Women & Service Providers*, July 2016; Apolot R., Tetui M. et al., *Maternal health challenges experienced by adolescents; could community score cards address them? A case study of Kibuku District– Uganda,* 2020, International Journal for Equity in Health.

75 Midwifery Services in Uganda – Issue Brief 02 – April 2017.

76 Ugandan Health Workers' and Mothers' Views and Experiences of the Quality of Maternity Care and Use of Informal Solutions – Qualitative Study, 2019.

or with the help of traditional birth attendants who lack the expertise and equipment to provide skilled care, especially where complications arise.[77] [78]

57. The situation is even more dire for adolescent girls. Uganda has a relatively high teenage pregnancy rate, with 25% of adolescents aged 15-19 years having begun childbearing.[79] Furthermore, 17.2% of the 6,000 maternal deaths each year are adolescent girls aged 15-19 years.[80] Many pregnant adolescents lack support from their parents, their partners and their community. This includes financial support, which means they often cannot afford to travel or seek maternal health services. Thus, they suffer psychological, emotional and verbal abuse and other forms of cruel and degrading treatment at health facilities because of their inability to pay for services.

58. During these experiences at health facilities, pregnant adolescents also face physical abuse, including beatings from parents and partners and psychological abuse, including denial of food by partners because they are pregnant. They are also more likely to be subjected to early and forced marriage because they are pregnant.[81][82]

59. From the foregoing, we see that the Uganda government's failure to ensure the acceptability and quality of maternal healthcare is resulting in adolescent girls being subjected to physical abuse (such as beatings and slaps), verbal abuse (such as berating, insults and comments that humiliate and shame) and emotional and psychological abuse (occasioned by the physical and verbal abuse as well as neglect) when they are seeking maternal health services.[83]

60. For adolescent girls, the situation is worsened by the government's failure to fulfil its obligation to address legal and socioeconomic factors that result in adverse health outcomes for adolescents[84] , such as laws, policies, guidelines and harmful cultural practices and traditional beliefs that criminalise and stigmatise adolescent sexuality, predominantly female adolescent sexuality. This failure facilitates the prevalence of traditional and cultural beliefs which justify and encourage abuse and cruelty against pregnant adolescent girls by parents and partners.

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77 Dantas J., Singh D. et al., Factors affecting utilization of health facilities for labour and childbirth: a case study from rural Uganda, BMC Pregnancy and Childbirth (2020).

78 Munabi-Babigumira S., Glenton C. et al., Ugandan health workers' and mothers' views and experiences of the quality of maternity care and the use of informal solutions: A qualitative study, PLoS ONE (2019).

79 Pg. 89, Uganda Demographic and Health Survey, 2016

80 Fact Sheet on Teenage Pregnancy, 2021, UNFPA Uganda (2021). Accessed on 6th December 2024. Available at: https://uganda.unfpa.org/sites/default/files/pub-pdf/teenpregnancy_factsheet_3.pdf

81 Apolot R., Tetui M. et al., Maternal health challenges experienced by adolescents; could community score cards address them? A case study of Kibuku District– Uganda, International Journal for Equity in Health (2020).

82 Cumber S., Atuhaire C. et al., Barriers and strategies needed to improve maternal health services among pregnant adolescents in Uganda: a qualitative study, Global Health Action (2022).

83 Pg. 7, Amicus Curiae Submissions of the Working Group on the issue of discrimination against women in law and in practice; the Special Rapporteur on Torture and other cruel, inhuman or degrading treatment or punishment, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; Special Rapporteur on the rights of persons with disabilities and the Special Rapporteur on violence against women, its causes and consequences on Denial of Abortion Services in Petition Number ADI/ADPF 5581, Office of the High Commissioner for Human Rights.

84 Committee on the Elimination of Discrimination Against Women, General recommendation No. 24: Article 12 of the Convention (women and health) (1999). Paragraph 12(b).

ii. Criminalisation of consensual non-exploitative sexual consensual non-exploitative sexual conduct.

61. Uganda's legislation criminalises consensual sexual conduct involving adolescents under the age of 18, thereby significantly affecting their rights to sexual and reproductive health. Currently, the Penal Code criminalises all sexual conduct involving minors, including consensual, non-exploitative and non-coercive sexual conduct between adolescents.

62. Under Section 129, the Penal Code creates the offence of defilement, which penalises individuals engaging in sexual acts with those under the age of 18. Any person who performs a sexual act with another who is below the age of 18 is liable for life imprisonment. Even when an individual *attempts* to, they can be imprisoned for up to eighteen years.

63. The Penal Code further codifies a form of 'aggravated defilement', which, upon conviction by the High Court, can lead to a death sentence.[85] The severity of the penalties, including life imprisonment for simple defilement and a death sentence for aggravated defilement, reflect a robust stance.

64. Adolescent girls are particularly affected by this as they could be criminalised for engaging in consensual sexual conduct. This can stifle their development and create fear of persecution. While circumstances such as the victim being below 14 or the offender having HIV are reasonable for intervention,[86] deeming simple defilement as a felony may be considered legislative overreach into adolescent girls' normal sexual development.

65. Section 129A of the Penal Code addresses cases where both parties are children between the ages of 12-18, directing them to be handled under Part X of the Children's Act, designated for child offenders. However, the Children's Act does not decriminalise the conduct, only offering lenient treatment for child offenders (e.g., allowing arrested children to be unconditionally released by police officers or be released on bond[87]).

66. The continued criminalisation of consensual sexual conduct for girls aged below 18 does not strike a balance between protection and empowerment. Further, the criminalisation of consensual sexual conduct is also extended to laws related to homosexuality in Uganda. In September 2023, the government passed the Anti-Homosexuality Act 2023, which has been defined as one of the world's harshest anti-LGBT laws.[88] The legislation includes the death penalty for "*serial offenders*" or for anyone having same-sex relations with a person with a disability, a child, or of advanced age, among others, under the offence of "*aggravated homosexuality"*. This recent criminalisation of consensual sexual conduct is deeply concerning as it pushes Uganda farther away from fulfilling CRC obligations. Criminalising consensual homosexual conduct creates barriers to healthcare, widening the gap in health disparities for LGBT women and adolescent girls. This criminalisation discourages them from seeking sexual and reproductive health services due to fear of persecution.

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85 Penal Code, Section 129.

86 Ibid, Section 129(5).

87 CRR, CEDAW 2022 Report, Section 89; Children Act.

88 Nyeko O., Kojoue L., *Ugandans Challenge Anti-Homosexuality Act: Court Has Opportunity to Strike Down Abusive Law*, available at https://www.hrw.org/news/2023/12/11/ugandans-challenge-anti-homosexuality-act.

Factual background

67. The Penal Code fails to recognise that adolescent girls engage in consensual and non-exploitative sexual conduct. Despite this legal stance, the demographic reality indicates that 18% of girls have their first sexual experience by age 15, rising to 62% by age 18.[89]

68. The 2022 Annual Crime Report, issued by the Ugandan police (the "Police Report"), identifies defilement as the most reported sexual crime in the country, totalling 12,580 cases that year.[90] While the statistics reveal disproportionate victimisation of women (12,470 females to 310 males), the consent element lacks clarity. Within the 15–17 years age group, 8,007 cases were reported, with only 314 involving victims defiled by suspects who are HIV positive, their guardians, or their biological parent.[91] Although further evidence is required, it can be reasonably assumed that outdated laws criminalising consensual conduct contribute to the rise in adolescent sexual incidents.

69. Further, Uganda trails behind other African countries on this matter. The majority of countries in Africa have set the age of consent for heterosexual sex at age 16 or younger, with a minority retaining the age of 18. Many countries with common law roots, such as Botswana, Namibia, South Africa, Zambia, and Zimbabwe, have set the age of sexual consent at 16 years of age.

Challenges

70. The criminalisation of consensual conduct among adolescents, coupled with active prosecution, poses significant challenges to the sexual and reproductive health of adolescent girls. First, criminalisation can prevent adolescent girls from seeking sexual and reproductive health information and services because they fear incurring criminal liability. Second, it can dissuade healthcare providers from providing adolescents with information and services for fear of incurring liability for facilitating criminal behaviour.[92] The combination of the two can have a disproportionate effect on adolescent girls as it increases the risk of adolescent pregnancy, unsafe abortions and contraction of STIs, including HIV/AIDS.[93] The 'best interests of the child' principle should guide the review of the law relating to consensual sex between adolescents."[94]

71. Further, the Anti-Homosexuality legislation has already impacted women and girls, limiting their ability to engage in consensual sexual conduct and access appropriate sexual and reproductive services and information. An Expert at the Human Rights Committee meeting, considering Uganda's second periodic report to the provisions of the International Covenant on Civil and Political Rights, expressed concern for the adoption of the Anti-Homosexuality law, as it reportedly intensified a hostile climate for LGBT individuals.[95] The Expert further added that suspects of

89 UDHS, p. 73.

90 Police Report, p. 46.

91 Id.

92 African Committee on Experts on the Rights and Welfare of the Child, General Comment No. 7 on Article 27 of the ACRWC: Sexual Exploitation (2021), paragraph 51.

93 CRR CEDAW 2022 Report.

94 Ibid., p. 142.

95 OHCHR, *In Dialogue with Uganda, Experts of the Human Rights Committee Commend Improvement of Prison Conditions, Raise Issues Concerning the Anti-Homosexuality Law and Free Elections*, June 28, 2023,

homosexuality faced detention based on mere suspicion, and healthcare professionals refrained from distributing safe sex materials, fearing accusations of "*promoting homosexuality.*"[96] Women and adolescent girls must have the freedom to make decisions about their sexual preferences and to access sexual and reproductive services without fear of prosecution and discrimination.

Thus, the Center and its partners respectfully urge the Committee to pose the following questions to the Government of Uganda;

(a) What measures are being put in place to address the lack of availability and geographical and financial accessibility of maternal health services, particularly for adolescent girls, especially in rural areas?
(b) What measures are being implemented to address the lack of equipment, commodities, and staff at health facilities at all levels, including health centres II, III, and IV?
(c) What measures are being put in place to address physical, mental, and verbal abuse, mistreatment and disrespect of pregnant adolescent girls in health facilities?
(d) What measures are being put in place to ensure redress for victims and survivors of physical, mental, and verbal abuse, mistreatment, and disrespect suffered when seeking maternal health services?
(e) What measures are being put in place to address socioeconomic factors that contribute to adverse health outcomes and justify abuse and violence against adolescent girls, such as stigma against female sexuality, particularly for young and unmarried adolescent girls?

We also request that the Committee consider making the following recommendation to the Government of Uganda:

(a) The Government of Uganda should put in place measures to address preventable maternal mortality and morbidity and abuse and violence in the context of access to maternal health care.
(b) We urge the Committee to posit that these measures should include legislative, policy, budgetary, administrative, and programmatic measures to ensure the availability, accessibility, quality, and acceptability of maternal health services for adolescent girls, especially those in rural areas.

C. Article 24 Lack of Access to Safe Abortion Care

i. Legal and Policy Framework on Safe Abortion Care

72. Uganda lacks a comprehensive legislative and policy framework to facilitate effective access to safe and legal abortion care nationwide. Article 22 (2) of the Constitution prohibits the deprivation of the life of any person, including an unborn child. It also provides that in some instances, the termination of a pregnancy is lawful by commanding that "*[n]o person has the right to terminate the life of an unborn child except as may be authorised by law*".[97] Thus, Article 22 (2) obligates the Parliament to make a law that would provide for instances under which the termination of a

available at: https://www.ohchr.org/en/news/2023/06/dialogue-uganda-experts-human-rights-committee-commend-improvement-prison-conditions.

96 *Id.*

97 Constitution, Article 22.

pregnancy would be permitted.[98] Despite almost three decades since the Constitution's promulgation, Ugandan policymakers have yet to pass the necessary legislative framework.

73. However, the Penal Code Act of Uganda (the "Penal Code") provides for criminal sanctions to several aspects of abortion, and, in the absence of any other law, it remains the authority on instances in which abortion is or is not permitted.[99] For example, Sections 141–143 and 212 criminalise abortion, imposing several penalties for attempts and procurement of abortion. Section 224 provides for a defence against prosecution for an offence relating to abortion.

74. Under Section 141, any person who unlawfully administers to any woman any poison or other noxious thing uses any force of any kind, or uses any other means on her with intent to cause a termination of a pregnancy can be liable to imprisonment for fourteen years. This offence also captures health service providers who, through any unlawful way, help and cause a woman to terminate a pregnancy.[100] Under Section 142, any woman who, to terminate a pregnancy, unlawfully administers to herself any poison or other noxious thing, uses any force of any kind, or uses any other means on herself, or permits any such things or means to be administered to or used on her, can be punished with imprisonment for seven years.[101]

75. Under Section 143, any person who supplies or procures anything knowing that it will be used unlawfully to terminate a pregnancy can be liable to imprisonment for three years.[102] This provision is broad in scope and can capture pharmacists who provide anything to a woman or any person, knowing that it will be used to terminate a pregnancy. The underlying feature of these three Sections is the *intent* to terminate the pregnancy.

76. Section 212 of the Penal Code criminalises unintended termination of pregnancy: "[a]*ny person who, when a woman is about to be delivered of a child, prevents the child from being born alive by any act or omission of such a nature that if the child had been born alive and had then died, he or she would be deemed to have unlawfully killed the child, commits a felony and is liable to imprisonment for life*".[103] While offence removes the element of intent, it adds the element of a child about to be delivered without defining who amounts to a child about to be delivered. It could be argued that this Section could capture a foetus which is capable of living on its own outside the uterus, in which case, the accused will deemed to have killed an unborn child.[104]

77. Notable is Section 224, which provides a defence to a person accused of any offences defined by Sections 141, 142, 143 and 212 of the Penal Code. Under Section 224, a person who, in good faith and with reasonable care and skill, performs a surgical operation upon an unborn child for the preservation of the mother's life is not criminally responsible. The operation's performance must be reasonable regarding the patient's state and all the circumstances.[105]

78. The above defence falls short in three key aspects: (i) it does not encompass modern abortion services beyond surgical procedures, such as medical abortion through pills; (ii) it lacks the

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98 According to Constitution, Article 79, only Parliament has powers to make laws on any matter.

99 Penal Code Act, as amended through the Penal Code (Amendment) Act, 2007 (Act No. 8 of 2007).

100 Ibid. Section 141.

101 Ibid. Section 142

102 Ibid. Section 143.

103 Ibid. Section 212.

104 Center for Reproductive Rights, *Facing Uganda's Law on Abortion, Experiences from Women & Service Providers*, July 2016, p. 6.

105 Penal Code, Section 224.

empowerment for women and adolescent girls to make choices regarding their pregnancy, as it only exempts health practitioners from criminal liability; and (iii) it fails to provide sufficient guidance to health professionals on the circumstances under which they can exercise their discretion to perform a surgical operation on the unborn child to save a mother's life. Given these limitations, urgent policy intervention is required to update the legislative framework on abortion in Uganda.

79. The MoH introduced the National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights in 2006, subsequently amended in 2012. These guidelines outline scenarios where abortion services can be considered. These include but are not limited to, situations where there is a severe maternal illness that threatens the health of a pregnant woman (e.g., severe cardiac disease, renal disease, severe pre-eclampsia and eclampsia) or severe foetal abnormalities (when the pregnancy is not viable); where the woman has cervical cancer or is HIV positive; or where the pregnancy is a result of rape, incest and defilement.[106] However, despite the guidelines, the absence of codification into law leaves a void in guiding the access to and provision of safe, legal abortion services in Uganda.

Jurisprudential Landscape

80. A notable example illustrating the broad application of the criminalisation of abortion in Uganda is the case of *Uganda v Kato Frederick*.[107] Frederick, a pharmacist, was accused of supplying drugs for abortion in violation of the Penal Code, and he faced legal consequences after providing medication to a young woman who was experiencing complications from an incomplete abortion. The woman ultimately gave birth to an "*abnormal growth child*" that was buried, and the police arrested her for having carried out an abortion. Despite the case being ultimately dismissed due to unfair delays and insufficient evidence, the repercussions impacted Fredrick's work and led to the closure of his pharmacy.[108] Such instances heighten concerns among health practitioners, deterring them from providing safe abortion services that are within the current law due to the legitimate fear of prosecution. This, in turn, deprives women and girls of access to safe abortions within the confines of the law, contributing to elevated maternal morbidity rates.

Challenges

81. The legal and political deadlock perpetuates the criminalisation of abortion, as indicated by police statistics. The 2022 Annual Crime Report, issued by the Uganda Police Force (the "Crime Report"), recorded 59 recorded abortion cases, marking an increase from the 56 cases in 2021.[109] The criminalisation of abortion, in turn, fuels an increase in unsafe abortion incidents due to the fear of legal repercussions and societal stigma, which leads women to resort to clandestine and unsafe methods.[110]

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106 Ministry of Health, *National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights* (4th edn, August 2017), p. 52.

107 Center for Health, Human Rights and Development, *Case Brief: Uganda v Kato Frederick (Criminal Case 56 of 2020)*, 2022.

108 Center for Health, Human Rights and Development, *Case Brief: Uganda v Kato Frederick (Criminal Case 56 of 2020)*, 2022.

109 Crime Report, p. 55.

110 Mulumba, M., Hasunira, R., Nabweteme, F., *Criminalisation of Abortion and Access to Post Abortion Care in Uganda, Community experiences and perceptions in Manafwa district*, 2014, available at https://searchworks.stanford.edu/view/11815325.

82. Interviews conducted by the Center reveal distressing stories of women and girls resorting to unsafe abortions to terminate an unwanted pregnancy, which in some cases have even life-threatening consequences. For example, one woman reported suffering excessive bleeding that resulted in her being hospitalised for two weeks, while another reported eight years of uncontrolled bleeding brought on by simple everyday actions such as standing, coughing, and laughing due to an unsafe abortion she received at the age of 13.[111]

83. An adolescent girl sought an unsafe abortion through a local older woman who provided her with herbs and left her a bush—the girl had to be taken to the hospital for the bleeding and uncontrollable fear for her safety.[112] Women and young girls should be able to access legal abortion services without having to face such terrifying realities. In Uganda, 23.5% of adolescent girls aged 15-19 are young mothers.[113] Further, slightly more than half (52%) of the pregnancies occurring among women and girls aged 15-49 are unintended, resulting in approximately 314,000 induced abortions each year. The majority of these abortions are conducted in unsafe conditions. Unfortunately, post-abortion care is only provided for approximately 30% of the abortions occurring among women and girls. This means that a significant number of women and girls lack access to post-abortion care.[114]

84. Consequently, unsafe abortion contributes to 26% of maternal deaths in the country.[115] Although the incidence of short-term and long-term morbidity arising from unsafe abortion is unknown, it is estimated to be higher than the incidences of death.[116]

85. Similarly, the rate of unsafe abortion and lack of access to post-abortion is not uniform across different groups of girls and young women. For instance, in northern Uganda, where most humanitarian camps are located and, therefore, where large communities of refugees and asylum seekers live, health facilities receive the highest number of cases of post-abortion complications, which implies a higher rate of unsafe abortion. Conversely, the Northern region has among the lowest number of health facilities providing post-abortion care. Consequently, the rate of abortion morbidity and mortality in Northern Uganda is 10% higher than the national average.[117] The mortality and morbidity arising from unsafe abortion cause severe physical and mental pain and suffering for young women and girls.[118] For instance, one woman who the Center interviewed as part of its research into the effects of the legal framework on access to safe abortion shared that as

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111 Center for Reproductive Rights, *Facing Uganda's Law on Abortion, Experiences from Women & Service Providers*, July 2016, p. 10.

112 Id.

113 Uganda Demographic and Health Survey 2022. Kampala, Uganda: Uganda Bureau of Statistics (UBOS).

114 Prada E., Atuyambe L. et al., Incidence of Induced Abortion in Uganda, 2013: New Estimates Since 2003, PLoS ONE 11(11), (2016).

115 Executive Summary, Standards and Guidelines on Reducing Morbidity and Mortality from Unsafe Abortion in Uganda (2015), Ministry of Health, Republic of Uganda (2015).

116 Pg. 10. Facing Uganda's Law on Abortion: Experiences from Women & Service Providers, The Center for Reproductive Rights and the Center for Health Human Rights and Development (2016).

117 Prada E., Atuyambe L. et al., Incidence of Induced Abortion in Uganda, 2013: New Estimates Since 2003, PLoS ONE 11(11), (2016).

118 Pg. 10, Amicus Curiae Submissions of the Working Group on the issue of discrimination against women in law and in practice; the Special Rapporteur on Torture and other cruel, inhuman or degrading treatment or punishment, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; Special Rapporteur on the rights of persons with disabilities and the Special Rapporteur on violence against women, its causes and consequences on Denial of Abortion Services in Petition Number ADI/ADPF 5581, Office of the High Commissioner for Human Rights.

a result of unsafe abortion, she had been bleeding continuously for eight years, especially when she laughs or coughs.

86. Additionally, the process of procuring an unsafe abortion also includes severe physical and mental suffering as the methods used involve inserting cassava sticks into the uterus, drinking poisonous herbs,[119] inserting crushed bottles into the uterus or drinking detergent.[120] For asylum-seeking and refugee women and girls, the discrimination they face based on their gender by not being able to access services required by women only, including emergency post-abortion care, is compounded by discrimination on the grounds of their refugee and asylum-seeking status, resulting in worse outcomes for them when it comes to abortion mortality and morbidity.

87. Additionally, this suffering can be attributed to the acquiescence of state officials as it primarily is caused by Uganda's failure to meet key elements of the minimum levels of satisfaction about the right to sexual and reproductive health, namely, the inability to decriminalise abortion and failure to take appropriate measures to prevent unsafe abortions.[121]

88. This assertion that Uganda has failed to decriminalise abortion stems from the fact that abortion is criminalised by Sections 141-143 of the Penal Code, which prohibits the unlawful provision of abortion services, seeking of abortion services and provision of drugs or other supplies for procuring abortions.[122] The Penal Code was passed in 1950 while Uganda was still a British colony. However, despite numerous amendments to the Code since Uganda gained independence, the government has failed to remove these provisions.

89. Due to a lack of clarity in the law on what constitutes a crime thereunder and what exceptions should, at the least, apply, these provisions are implemented as a blanket criminalisation of abortion. While the exact numbers are not known, women, girls and health service providers have been arrested, prosecuted, convicted, and imprisoned based on these provisions. Nonetheless, research conducted by the Center found that police have arrested and charged women and healthcare providers on suspicions of seeking and providing abortion care, respectively, without investigation into whether the abortions sought and provided were unlawful or not.

90. This situation is compounded at trial of abortion-related cases where the woman or girl has the burden of proving her innocence rather than the prosecution having the burden of proving her guilt as required by law. For further context, the research also documented the situation of a woman who

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119 Pg. 14-15, Facing Uganda's Law on Abortion: Experiences from Women & Service Providers, The Center for Reproductive Rights and the Center for Health Human Rights and Development (2016).

120 Nara R., Banura A. et al., Exploring Congolese refugees' experiences with abortion care in Uganda: a multi-methods qualitative study, Sexual and Reproductive Health Matters (2019).

121 Pg. 5, Amicus Curiae Submissions of the Working Group on the issue of discrimination against women in law and in practice; the Special Rapporteur on Torture and other cruel, inhuman or degrading treatment or punishment, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; Special Rapporteur on the rights of persons with disabilities and the Special Rapporteur on violence against women, its causes and consequences on Denial of Abortion Services in Petition Number ADI/ADPF 5581, Office of the High Commissioner for Human Rights.

122 Section 141-143, Penal Code Act CAP 120, Republic of Uganda.

had been convicted under these provisions and served a 5-month sentence. She admitted to meeting other women who had been imprisoned for the same offence during her incarceration.[123]

91. This apparent conflict between law and policy has led many in Uganda, including policymakers, traditional and cultural leaders and service providers, to believe that abortion is illegal without any exceptions. Also, although a significant number believe that abortion is only allowed to save the life of the pregnant person, they are unsure what this exception means in practice.

92. The conflict in laws and policies on abortion has also resulted in misinformation. For instance, some duty bearers believe that, for an abortion to be legal, the threat to the pregnant person's life must be certified by a plurality of healthcare providers.[124]

93. Finally, the government of Uganda has also failed to prevent unsafe abortion by taking measures that cause further confusion and, unfortunately, lend credence to the claims that abortion is fully criminalised in Uganda. For instance, in 2015, the Ministry of Health developed and launched the Standards and Guidelines on Reducing Morbidity and Mortality from Unsafe Abortion in Uganda ("the Standards and Guidelines"). These Standards and Guidelines provided for safe abortion as a measure to reduce maternal mortality and morbidity. Because of this, they were withdrawn 6 months after launch with no explanation and no alternative action taken to address the gap they left.

Thus, the Center and its partners respectfully urge the Committee to pose the following questions to the Government of Uganda:

d) What measures are being put in place to decriminalise abortion in Uganda's laws?
e) What measures are being put in place to enact a law providing for safe and legal abortion?
f) What measures are being put in place to create public awareness among adolescent girls, healthcare providers and state actors on the instances in which abortion can be legally sought and provided in Uganda?

We also request that the Committee consider making the following recommendation to the Government of Uganda:

b) The Government of Uganda should first and foremost put in place measures to ensure accessibility and quality of safe, comprehensive abortion care for all girls, including refugee and asylum-seeking girls, to the full extent allowed by laws and policies in Uganda;

Urge the government of Uganda to reinstate and disseminate the withdrawn guidelines that were intended to address maternal mortalities and morbidities from unsafe abortion; enact legislation on legal abortion required by Article 22(2) of the Constitution; and take action to decriminalise abortion.

[123] Pg. 25 and 33, Facing Uganda's Law on Abortion: Experiences from Women & Service Providers, The Center for Reproductive Rights and the Center for Health Human Rights and Development (2016).
[124] Moore A., Kibombo R. et al., Ugandan opinion-leaders' knowledge and perceptions of unsafe abortion, Health Policy and Planning (2014)

Conclusion

94. In sum and informed by the foregoing analysis of the select themes and issues on Uganda's obligations under the Convention, namely on access to information and education on contraception, consent to services, dignified maternal health, criminalisation of non-consensual and no exploitative sexual conduct and access to safe abortion care, the Center and its partners' posit as follows;

    a. Legal barriers, policy hesitations and systemic issues contribute to high rates of adolescent pregnancies and unmet family planning needs. Importantly, continued resistance from the government to lower the minimum age for adolescent girls to access modern contraceptives will continue to impede progress and full realisation of access to information.

    b. Insufficient access to sexual and reproductive health information and education has significant negative consequences for women and girls, including early and unwanted pregnancies, unsafe abortions and a higher risk of sexually transmitted infection. Furthermore, a lack of adequate information is a barrier to accessing contraceptives and maternal healthcare services.

    c. The issue of access to adequate sexual and reproductive health information and sexual education in Uganda presents a multifaceted challenge with far-reaching implications for the well-being of women and adolescent girls. The alarming rates of adolescent pregnancies, coupled with low contraceptive usage, underscore the critical need for accurate and comprehensive sexual and reproductive health information and sexual education. Urgent and comprehensive measures are imperative to address the pressing need for accurate, unbiased, and accessible sexual health education, ensuring the well-being and empowerment of women and adolescent girls in Uganda.

    d. Adolescent girls in Uganda currently face difficulties in accessing sexual and reproductive health services and information freely. Conditioning access to sexual and reproductive services, including safe abortion care and contraception, on the consent of a third party, such as a parent, compounds the difficulties in ensuring that adolescent girls receive adequate care.

    e. Uganda faces critical challenges in maternal healthcare, marked by a high maternal mortality rate and significant gaps in the healthcare system. The limited accessibility to proper healthcare facilities and services contributes to an elevated neonatal mortality rate, contradicting Uganda's dedication to maintaining a high standard of healthcare.

    f. The ongoing broad criminalisation of abortion in Uganda not only jeopardises the health and well-being of women and girls but also contributes to elevated maternal mortality rates and unsafe abortion incidents. The outdated Penal Code and the absence of comprehensive legal frameworks on abortion perpetuate the criminalisation of abortion, leading to distressing consequences for women and adolescent girls. Urgent legislative action is crucial to align with the CRC to ensure the provision of safe and accessible abortion services and safeguard women's reproductive rights.

    g. Uganda's blanket ban on consensual sexual activity involving adolescents under the age of 18 (where parties involved are close in age or both underage) appears to be at odds with

the international practice that commonly sets the age of consent for heterosexual sex at age 16 or younger. While the statistics do not separately indicate the proportion of minor-to-minor non-coercive cases, the data clearly shows that the impact of the defilement provisions is significant. Criminalising consensual sexual conduct has the effect of stigmatising sexual activity with peers, which, in turn, hinders access to sexual and reproductive services and results in a criminal record at a young age, which has a knock-on impact on development.[125] Consequently, the blanket criminalisation of consensual sexual intercourse between adolescents is a punitive, rather than evidence-based, restriction on their sexual and reproductive rights. Solutions include reducing the age of consent to 16 and introducing "*close-in-age provisions*" allowing adolescents over a certain age to consent to sexual interactions with persons who are less than five years older.[126]

h. Uganda has an obligation to protect the rights of adolescent girls to make their own sexual decisions. The state needs to be able to strike a balance between protecting girls and respecting their evolving capacities when legislating on adolescent sexual conduct. Uganda needs to ensure this balance by not criminalising consensual, non-exploitative, non-coercive sexual conduct between adolescents. Consequently, the current legal framework, namely the Penal Code, has the potential to influence the developmental paths of adolescent girls negatively and impede their access to appropriate sexual and reproductive healthcare.

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125 Center for Reproductive Rights, Federation of Women Lawyers, Criminalizing Adolescence: A Call to Reform the Sexual Offences Act, Briefing Paper.

126 Leah Amayo Ondeng'e, A Critique of the Criminalization of Consensual Sexual Interaction Between Adolescents in Comparative Jurisdictions, pp. 38-39.