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A sexual and reproductive health and rights issue in Uganda: the situation on maternal health.

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Abbreviations and Acronyms

CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CPR	Contraceptive Prevalence Rate
FP	Family Planning
GE	Gender Equality
HIV/AIDS	Human immunodeficiency virus infection / acquired immunodeficiency syndrome
ICPD	International Conference on Population and Development
MDG	Millennium Development Goal
MOFPED	Ministry of finance, planning and economic development
MOH	Ministry of Health
MMR	Maternal Mortality Ratio
NGOs	Non- Governmental Organizations
PFA	Platform of Action
POA	Plan of Action
RH	Reproductive Health
SRH	Sexual and Reproductive Health
TMBs	Treaty Monitoring Bodies
UDHS	Uganda Demographic and Health Survey
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UWONET	Uganda Women's Network
WHO	World Health Organization

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Abstract

The Beijing Platform for Action and the International Conference on Population and Development Plan of Action marked a paradigmatic shift in the women´s rights struggle in recognizing sexual and reproductive health (SRH), particularly maternal health, as a key human right, which must be prioritized to advance development efforts and achieve gender equality. Two decades later, 6000 women in Uganda continue to die annually giving birth from preventable complications, the leading cause of maternal death in young women aged 15-19 years. This suggests that the Government of Uganda is failing to comply with the health obligations and the Millennium Development Goal (MDG) 5a target that it has committed to for its citizens. This paper analyses the SRH related legal and policy frameworks in Uganda vis á vis the unequal gender relations deeply rooted in social, cultural and patriarchal patterns where the most oppressed, women, are denied their core right, the right to life. The paper will use an analytical gender perspective and human rights based approach to argue for the need to amend the policies and programmes already in place, the need to address the roots of oppression buried in gender systems and sex stereotyping and address the gender discriminatory practices that still prevail through enactment, resourcing and implementation of gender responsive laws, policies and programmes.

1. Introduction

This paper will focus on the status of sexual and reproductive health and rights in Uganda with emphasis on poor maternal health as a human rights concern and a consequence of gender inequalities. This paper will provide a critical analysis of the legal and policy framework for sexual and reproductive health, focusing on maternal health as well as some of the social-cultural barriers hindering progress towards fulfilling human rights and the regional and international priorities and targets agreed upon to protect and fulfill sexual and reproductive health and rights (SRHR).

The overall goal of the paper is to analyze the legal and policy frameworks on sexual and reproductive health and rights in Uganda from a gender/ feminist analytical perspective and human rights-based approach.

The specific aims are:

- Identify the gaps in the legislative and policy framework on sexual and reproductive health and rights that impact maternal health care and act as a barrier to the fulfillment of sexual and reproductive rights in Uganda.
- Analyze some social-cultural practices that undermine women´s empowerment and enjoyment of their sexual and reproductive health and rights in Uganda which promotes gender inequality resulting in poor maternal health or maternal mortality.

The Beijing Platform of Action (Beijing PFA), a consensus document of the 4th world conference on women and the International Conference on Population and Development Plan of Action (ICPD PoA), marked a paradigmatic shift in which the international community recognized that human rights, including sexual and reproductive health and rights, must be prioritized to advance development and achieve gender equality (The World Bank, 2011).

Since the early 1990s, there has been increasing international recognition that high rates of maternal mortality constitute a violation of women's human

rights. This has been reflected recently in the June 2009 resolution of the United Nations (UN) Human Rights Council on "Preventable Maternal Mortality, Morbidity and Human Rights." UN Treaty Monitoring Bodies (TMBs) urged governments to ensure women's access to maternal healthcare. It further called for abolishing social practices that negatively impact women's health (Center for Reproductive Rights, 2010) (see further, chapter 3).

Although the global priorities for women were set over 15 years ago, to promote universal access to family planning, sexual and reproductive health services and rights, this seems to be far from being achieved for Uganda. To a larger extent, these priorities, policy frameworks, programmes and commitments have remained on paper. The slow progress in achieving the obligations is a clear indication that rights of women and girls is not a priority for the country. It is also an indication of the prevailing inequalities because of one's gender. The 2011 Human Development Index, ranked Uganda in the 161st place out of 187 countries, with a score of 0.446. The Gender Inequality Index is 0.577 (116th place out of 146 countries) where 0 denotes inequality and 1 denotes equality (Klugman, 2011). This clearly depicts that gender equality and women´s empowerment which translates in improved health and respect for sexual and reproductive rights will continue to be a distant reality for women and girls.

Globally, an estimated 287,000 maternal deaths occurred in 2010; while this is a decline of 47% from levels in 1990, the maternal mortality ratio in developing regions was 15 times higher than in developed regions (56%) (World Health Organisation, 2012, World Health Organization et al., 2012).

Uganda has a high maternal mortality ratio of 435/100,000 live births (Ministry of Finance Planning and Economic Development, 2010a) and accounts for 18 percent of global deaths to women age 15-49. Every day, an estimated 16 women die giving birth due to preventable compilations: on

average, 1 death every hour and a half and nearly 6000 mothers die annually. For every maternal death, about 6 other mothers will have developed complications, including obstetrics fistula that is estimated at 2.6%, most of whom have not been repaired (Uganda Bureau of Statistics, 2012). Half of Uganda´s population is below 18 years, with the adolescent-specific fertility rate at 24%. The overall contraceptive prevalence rate is 29.9% and the unmet need for family planning at 34.3% (ibid). While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health and even death hence the focus of my paper.

Evidence supports the claim that maternal health can be largely achieved; if sexual and reproductive health and rights are respected and the legal and policy framework that address SRHR, is enforced (Center for Reproductive Rights, 2013). Important to note is that, sexual and reproductive health rights do not represent a new set of rights but are rights already recognized implicitly or explicitly in national laws, international human rights documents and other relevant United Nations consensus documents. The inclusion and acceptance of maternal health as a human rights issue and an international development agenda has over the years gained momentum as a pillar for gender equality and empowerment. The ICPD PoA re-emphasized the need for population and development to move beyond the numbers and ensure every person including the most marginalized rural women and girls' count (Greene et al., 2012).

Sexual and reproductive health has been defined in the ICPD PoA:

> *"the ability to have a satisfying and safe sex life and the capability to reproduce. It also involves the freedom to decide if, when and how often to do so with the right to make decisions on family size, timing of marriage and matters of sexual and reproductive health services, free of coercion, discrimination and violence"* (United Nations, 1994).

World Health Organization (WHO) defines reproductive rights to incorporate both freedoms and entitlements involving social, civil, political, economic and cultural rights and maternal health (MH) as a sexual and reproductive right of

women during pregnancy, childbirth and the postpartum period. It further defines maternal death as occurring during pregnancy or within 42 days of termination of pregnancy from any direct or indirect cause related to, or aggravated by the pregnancy or its management (World Health Organization et al., 2012).

The Special Rapporteur on Health of the Human Rights Council affirmed that the right to sexual and reproductive health is a fundamental part of the right to health, noting that States must therefore ensure that this aspect of the right to health is fully realized (United Nations General Assembly, 2011). The right to health was re-defined by the Committee on Economic, Social and Cultural Rights in its General Comment No. 14 to include measures to improve maternal health, and sexual and reproductive health services (ibid page 4).

The methodology involved a desk review of the existing literature taking into account already published information nationally and internationally, reports from the United Nations organizations and committees and Special Rapporteur on Health, reports of international treaty bodies monitoring and human rights principles. Priority was given to organizations and institutions whose core mandate is in line with promoting health, reproductive rights, gender equality and human rights in their development agenda e.g. World Health Organization, the World Bank, United Nations Population Fund (UNFPA), Center for Reproductive Rights, and Uganda Women's Network (UWONET).

An analysis of the legal and policy framework on SRHR nationally, regionally and internationally was conducted to review the policy environment vis-a vis the social-cultural practices that undermine the status of women and girls resulting in the high maternal deaths and poor health outcomes. The social practices which the paper will focus on include early marriage and forced marriage for girls, a rural custom, which has huge devastating effects including gender inequality and health related complications. The practice of bride price which to date, has led to high prevalence rates of violence in homes/

domestic violence in Uganda, increased the vulnerability of women who are considered property and undermined women's dignity reducing her existence to re-productive and labor functions within the household (MIFUMI, 2012). The unmet need and limited access to contraception is a concern which greatly impacts on people's ability to choose and control their lives and has been shown to affect women´s health in particular. All the above issues are pertinent problems in Uganda and thus warrant a closer look.

The paper will conclude with some recommendations to improve maternal health in Uganda. It will also seek to identify the gaps in the legal and policy framework that need action at different levels to promote sexual and reproductive rights as human rights concern and equality between women and men while considering the access and benefit of health commodities for both women and men without constrains by the social and traditional beliefs.

2. Legal and policy framework on sexual and reproductive health and rights (SRHR) in Uganda

Laws protecting sexual and reproductive health are rarely or inadequately enforced, largely because historically, the reproductive function was often viewed as "business as usual" which does not warrant attention, part of a larger and systematic discrimination against women (Cook, 1992).

The 1994 ICPD shift committed states, including Uganda to adopt a multi-dimensional approach defined by freedom, empowerment and fulfillment of human rights, which implicitly included the right to comprehensive sexual and reproductive health. It called for policy and legislative reform to challenge the traditional and cultural norms which have perpetrated inequalities and continue to obstruct women's access to reproductive health services (Reddy and Sen, 2013).

This chapter highlights the legal and policy framework at national level that corresponds to international commitments which seeks to eliminate gender

based discrimination, facilitates women's rights to sexual and reproductive health and promotes gender equality and equity.

Uganda´s Human Rights Commitments

Uganda is a signatory to numerous, regional and international human rights instruments (see in detail Annex I) which set the standard for protection, and enforcement of fundamental rights, including sexual and reproductive rights.

The Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), the international bill of rights for women, is an international legal instrument that articulates and advocates women's human rights. It defines what constitutes discrimination against women and sets up an agenda for national action to end such discrimination. Uganda ratified CEDAW in 1985 making it bound to the gender and human rights standards set therein (United Nations General Assembly, 1979)

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, better known as the Maputo Protocol, was ratified in 2010. The instrument supports the realization of all human rights for women in Africa; the comprehensive rights include control of their reproductive health (African Union, 2003).

Positive strides have been made in operationalizing these instruments in Uganda through the domestication process. While it appears that Uganda's speedy domestication process exhibits commitment to advance sexual and reproductive health rights for women to reduce health concerns such as maternal mortality, many of these policies and laws exist in theory and discriminatory practices against women still exist, a concern that has been raised by the CEDAW Committee monitoring reports for Uganda (Uganda Women's Network, 2010).

The Constitution of the Republic of Uganda of 1995 sets the tone for equality and non-discrimination for all and includes anti-discriminatory provisions condemning any custom that contradicts the realization of human rights. It is

however interesting to consider the 24th February 2014 human rights setback where the controversial legislation - the Anti-Homosexuality Bill (2014) - which infringes on fundamental rights to non-discrimination and equality, as well as the rights to sexuality, privacy, and freedom of expression, thought, assembly and association was assented into law. The law fosters homophobia and stigmatization hence defying international human rights standards on equal and human treatment for all.

The Uganda National Policy Guidelines and Service Standards for Reproductive Health (RH) services from 2001 sets the standards for SRH services for Uganda and is a guiding framework for results oriented RH programming at the national level (Ministry of Health, 2001). The Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda (2007-2015), as well as the Strategy to Improve Reproductive Health in Uganda (2005-2010) informed the development of a Comprehensive Reproductive Health Plan. This is in line with priority policy issues in the National Health Policy II (2009/10 – 2019/20) enforced by the ministry of health. It recognizes that the improvement of maternal health and reduction of maternal mortality in particular requires commitment at all levels through a multi-sectoral approach including education, transport , communication, and gender equality to address culture, traditions, vulnerabilities and inequities. It defines the path the government is taking to accelerate the reduction of maternal deaths utilizing health systems/structures from community to national level (Ministry of Health, 2007). The Reproductive Health Commodity Security Strategic Plan (2010/11- 2014/15), being implemented by the Ministry of Health, compliments the Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda to address the poor state of sexual and reproductive health and limited access to and use of reproductive health commodities for a large majority of Uganda's population.

As critical and ground breaking as these policies and programmes seem, they are blind to the existent social-economic and gendered society constructions within the prevailing patriarchal patterns and expectations of women's subordination to men. Societies where the poor status of a woman stripes her of all her decision making capacities, greatly impacts on her choices to access RH commodities and services. The unmet need and fertility rate is still high, impacting on maternal health outcomes.

The Uganda Demographic and Health Survey attempts to explain the power dynamics involved. A woman's method of contraception is largely dependent on her self-image and empowerment where most women choose methods that are easier to conceal from husbands or partners such as injectable (Uganda Bureau of Statistics, 2012). If the government of Uganda continues to develop gender blind programmes, even the meager resource invested for SRHS will remain an illusion for the 6000 mothers who hope to survive the complications, or even beat death while giving birth.

3. Maternal health/Sexual and reproductive health issues from a gender and human rights perspective.

Gender is defined as the social constructed attributes and opportunities associated with being male or female which are learned through the socialization process. It determines what is expected, allowed and valued in a man, woman, boy or girl in a given context/ society (UN Women, 2013). For instance, caring for the sick and elderly is female gendered while success in politics is male gendered. It is obvious that women can be political and men care givers, but seen as a far possibility for one to assume a gender role at variance with one's sex.

This chapter will analyze the legal and policy frameworks on sexual and reproductive rights in Uganda as a key human right for women vis á vis the gendered discourse and social-cultural considerations that make women's issues invisible.

Traditionally, sexual and reproductive rights raise critical issues around sexuality and morality. This is often because these rights are part of the triple gender roles of women in society- reproduction, production and community socializing, functions assumed inferior and servile (Berer, 2012). While rural communities continue to consider, the reproductive role of bearing children, the principal duty of women, this has been criticized by feminists who view women's bodies as a site for oppression of women by men. In the north eastern region of Uganda, -Karamoja region which is mostly a rural nomadic/ pastoral community, I learnt through my field work that households have preference for the male child. A home that has only given birth to daughters is considered *'a black family'* although there are numerous key roles the girls play. For instance the girls in this community are responsible for building (construction) of the houses, the fencing of the homesteads and are a source of wealth for the family particularly during the traditional marriage ceremony where the exchange of the girls for goods- often cattle is the practice (Hague et al., 2011).

The notion of hegemonic masculinity among the poorer societies is manifested through the breadwinner ideologies and number of children (Groes-Greene, 2009). The high fertility rate of 6.7 births per woman in Uganda is an indication of the burden shifted to women for maintaining the male ego through the number of children. It is however, interesting to realize that the cost to women's health of discharging this duty (reproductive roles) has gone unrecognized being viewed as "business as usual" which is not an important issue. This largely contributes to health risks, complications or sometimes maternal deaths (Corre^, 2005).

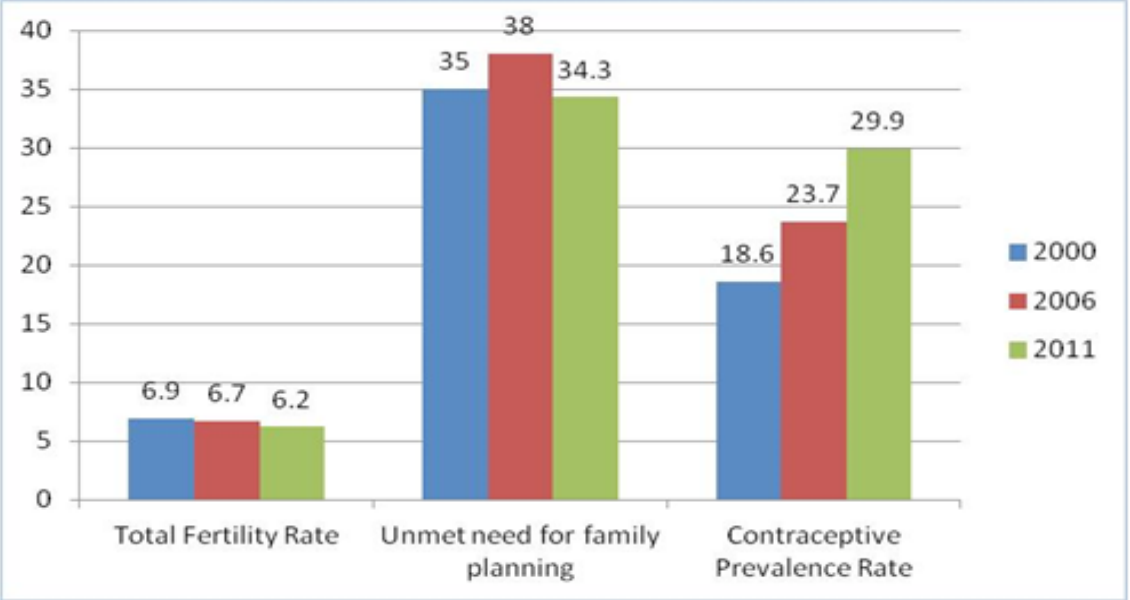
An analysis of three social-cultural considerations which re-enforce gender based discrimination and impede on women´s rights to sexual and reproductive health and rights in Uganda; Inaccessibility and limited information on family planning (FP), early marriage/early pregnancy, and the practice of bride price, will be the focus.

3.1. Inaccessibility and limited information on family planning: a concern for gender equality and human rights

Implicit in the ICPD definition, SRH is the right of women, girls, boys and men to be informed and have access to safe, affordable, effective and acceptable method of family planning of their choice (United Nations, 1994). Family planning, therefore, offers couples and individuals the ability to anticipate and attain the desired number of children through spacing and timing of their births. This may be through the treatment of involuntary infertility and contraception (Ministry of Health, 2001).

A total of 867 million women of childbearing age in developing countries have a need for modern contraceptives. Of that total, 645 million have access to them but a staggering 222 million still do not (Greene et al., 2012). In Uganda, research shows that each year, over 900,000 pregnancies are both unintended and unplanned (Kizza, 2013).

According to Uganda Demographic and Health Survey 2011, the unmet need for family planning remains currently high at 34.3%. This is above the government's target in the Health Sector Strategic and Investment Plan (HSSIP) to reduce the unmet need for family planning in Uganda to 20% by 2015. While contraceptive prevalence rate (CPR) for modern methods remains low at 29.9% with minimal increases, it is currently below the HSSIP target of 35% in 2015. Contraceptive supplies play a big role in meeting the unmet need. In Uganda if all women could access contraceptives leading to reduction of unmet need to below 5%, the CPR would increase up to 65%. Figure 1, shows Uganda's Total Fertility Rate, Contraceptive Prevalence Rate and Unmet need for Family Planning.



Source: (Action Group for Health Human Rights and HIV/AIDS (AGHA-U), 2012)

The high unmet need has been largely influenced by the limited access to and use of reproductive health commodities for the majority of the population. The existing patriarchal patterns which maintain male power controls public and private sphere including women's bodies which impacts on health seeking behavior. With reproductive roles feminized, the women who hold underprivileged status have limited or no choices available to protect themselves; women cannot control the timing of sexual intercourse, may not afford the means to prevent pregnancies, and lives in a society where safe and legal abortion is not easily available (Berer, 2012).

The contemporary family planning (FP) and population discourse and technologies has often been characterized in feminine terms which created a vacuum that has seen few men involved in FP discussions or child care. This re-emphasizes the gendered nature of child bearing and motherhood (Richey, 2004). For example, the Employment Act of Uganda (2006) is still framed within the ideologies of the welfare approach; it allows a father to take only four days as parental leave while a mother takes 60 working days, the policy environment clearly feminizes reproductive functions.

The gendered power dynamics on sexuality

The social- cultural systems re-enforces this unequal power dynamics which limit people's access and use of FP. Culture inhibits partners from openly discussing sex, sexuality, reproductive decisions or contraception within marriage, leaving many potential health seekers, often the women ignorant about their needs and at risk of unwanted/un planned pregnancies (Jacobson, 2000). Spousal discussion of sexual matters in these settings is highly discouraged making negotiation for safer sex which is viewed as challenge to manhood associated with many children much more difficult. Subtly methods are used for sexuality matters and a man's use of a condom may itself be a powerful nonverbal indicator of approval for family planning (DeRose et al., 2004)

Religion and tradition have also been used as justifications to impede on women's rights to sexual and reproductive health services and commodities. Religious scriptures such as; "multiply and fill the world" are repeated preached and christians using FP condemned for sin. Tradition similarly views family planning services as copied western practices that are considered foreign and taboo which seek to erode communities.

The failure to help women fulfill their spacing desires derives from society perceptions which reduce women's value to only fulfilling her feminine role of motherhood. Tong refers to Betty Friedan's, 1963 famous book *"Feminine mystique",* which criticized the assumptions that a woman with an identity, enjoying equality and even political power could not love, need to be loved by a man or be a good mother concurrently (Tong, 2009). To think that women should not access and utilize contraception, for fear of controlling outcomes such as unwanted pregnancies is limiting to a woman's development as a full human being/person and an under estimation of her full potential(ibid).

According to Gayle Rubin (2009), society has defined feminine and masculine roles and identities, in relation to biological sexuality which defines human activity. It empowers men and disempowers women labeling them as weaker

and less important in society increasing women's subordination and vulnerabilities. High birth rates and unintended pregnancies have been resultant of the limited or delayed choices to access RH commodities or services (Tong, 2009). The choices are much narrower for women who would wish to procure an abortion driving several young girls to opt for unsafe abortion which has led to tragedy. In 2008, the Uganda ministry of health, estimated that abortion related causes, accounted for 26% of all maternal mortality cases, considerably higher than the WHO estimate for East Africa which is -18% and 13% globally (Guttmacher Institute, 2013).

In the ideal world, sexual partners decide if and when to have children, they discuss the spacing of the children and the method of family planning to avoid unwanted pregnancies and other health risks. If one partner suffers from a sexual transmitted infection, they work together on ways to protect the other. The Ugandan reality is shaped by a social-cultural climate where the most oppressed, women, have no voice and cannot dare discuss issues around sexuality and reproductive rights. Women have no control over their bodies and sexuality because hegemonic masculinities expect a man, who has control over her, should know about sex. He is initiated by peers to have multiple partners at an early age as part of his learning and society expects women to be "good women" who are virgins and unaware of sex and sexuality (Jacobson, 2000).

Although clause 3.6 of the 2001 National Policy guidelines and standards for RH services does not require verbal or written consent from parents, guardians or spouses to access FP commodities and services, an illiterate rural woman whose opportunities were abruptly snatched away from her and is entirely dependent on her husband for livelihood must seek permission even in dire circumstances for fear of being punished for being a bad woman because she made decisions about her body and sexuality without her husband's consent. Women who accesses FP may be forced to have sex more regularly because the likelihood of unwanted pregnancies is diminished (ibid).

Does the legal and policy framework promote SRH Services: family planning?

Two decades after the International consensus on the ICPD programme of action, Uganda has made significant steps to promote and ensure sexual and reproductive health and rights services. This progress has been realized through policies and programmes which play a pivotal role in advancing rights, health and gender equality.

The National Development Plan 2010/11- 2014/15, the overall development framework, of the government of Uganda has prioritized the need to improve family planning use and access in the country. The plan seeks to promote overall development of the society and of women in particular. Traditionally, women have limited choices in reproductive decisions and the inability to control childbirth or protect themselves has led to complications, ill health and even death. One of the goals outlined in the plan is to reduce the unmet need by ensuring accessibility and availability of family planning services, especially in the rural areas where nearly 87% of the population lives (Global Health Initiative- Uganda, 2011).

The 2008 National Population Policy and the National Population Action Plan of 2010 also puts special emphasis on SRHR particularly family planning and reproductive commodity security, including use of contraceptives (Ministry of Finance Planning and Economic Development, 2010b) in line with the strategies in the HSSIP (2010/11-2014/15). This is geared towards improvement of overall sexual and reproductive health and rights of the population. Goals include provision of integrated family planning services in all health facilities at all levels, procurement and distribution of contraceptives to men and women of reproductive age, and design of programs to engage men in family planning services and use. Historically, reproductive health technologies were termed as feminine issues which created a gap and left men disinterested in the FP discourse until their wives died during child birth or developed complications; The Population Action Plan is cognizant of the gendered power relations that affect access and use for women who have

limited decision making powers, a positive step by the government (Ministry of Finance Planning and Economic Development, 2010b).

While the Ugandan government seems to be on track in terms of RH programmes aimed to address the unmet need of contraceptives and improve accessibility while, recommitting to the MDGs, the reality in practice is that implementation and enforcement of the policies is slow and lagging behind. Approximately 6000 mothers' lives are lost annually from preventable complications, which could have been avoided with universal access to FP. Additionally, the ministry of health research shows that for every woman who dies, six survive with chronic and devastating ill health such as obstetric fistula (Ministry of Health, 2007).

The Constitution in Article 22(2) which seeks to legalize abortion, a concern leading to 26% of the maternal deaths, no policy has given effect to this article. The current penal code further penalizes unlawful abortion for a maximum of up to 14 years prison sentence which has left health practitioners afraid of procuring abortions even in instances where the mother's life is at risk (Guttmacher Institute, 2013). The legal framework appears to be very contradictory and confusing to apply. The numerous progressive SRH policies to advance SRHR, gender equality and human rights, are still on paper and seem not to have translated into reality.

Uganda and the Marriage and Divorce Bill

Human rights and women activists have since 1948, struggled to advance the Marriage and Divorce Bill (2009), a gender responsive Bill, which seeks to challenge tradition and culture on sensitive issues, not openly discussed such as sexual and reproductive rights. The Bill promotes equality and rights within the marital union empowering women to make decisions as equal partners around issues of sexuality, health, property, and their well-being. The Bill challenges the characteristics of hegemonic masculinity which expects all the decisions including control of a woman's body to be made by her husband/men.

Legislators, religious and cultural leaders who comprise a larger majority of the decision making positions in these Ugandan institutions are male. They are at the fore front of opposing the Bill which disregards redundant customary norms that still perpetrate male control and power and re-enforce women subordination and dependency such as illegalizing marital rape, a symbol of male domination within the family (Hore, 2013). A large majority of the postpartum complications including fistula has been caused by husbands who force their wives to have sexual intercourse soon after giving birth; after all, sexual intercourse in marriage is their right.

The CEDAW Committee in their 2010 report urged the government to expeditiously pass the Marriage and Divorce Bill which seeks to advance gender equality within the marriage institution. The Committee highlighted the limited knowledge of and inaccessibility of family planning information and services as challenges for rural women and adolescent girls and boys to control unwanted pregnancies and STIs including HIV. In 2012, over 140,000 people became infected with HIV (The New Vision, 2013).

This confirms that respect for women's sexual and reproductive rights is far from reality. The patriarchy system is very dominant and the hegemonic masculinities will not allow gendered legislation which is passive to "overturn" the power dynamics (Global Health Initiative- Uganda, 2011). The Bill has been shelved again, an indication that the state is not yet ready to confront tradition which place men in powerful and controlling positions while leaving women more vulnerable to disease, ill-health, complications, violence and with a lower status where they cannot make decisions.

Uganda and the Maputo Protocol

The Protocol on the Rights of Women in Africa, Maputo Protocol (African Union, 2003) affirms reproductive choice and autonomy as a key human right. This cutting-edge Protocol represents the first time that an international human rights instrument has explicitly articulated a woman's right to abortion in certain cases. According to Adrienne Germain, the population field has

hardly promoted condoms, and only recently introduced emergency contraception but is still shying from safe abortion which has caused enormous tragedy (Corre^ et al., 2005).

In 2010, as, Uganda prepared to host the Common Wealth Heads of State meeting, it was under the spotlight to ratify the Protocol. Indeed, it was ratified in July, that year, with two reservations, both relating to Article 14 on sexual and reproductive health rights.

The first reservation pertains to the right to control one's fertility in Article 14(1) which promotes "*the rights for women to decide whether to have children, the number of children, spacing while empowered to choose a method of contraception and the right to self – protection against sexually transmitted infections, including HIV/AIDS".* Social and cultural systems dictate that women have no control over their sex lives. Wives are not allowed to refuse sex or to use a condom even if the husband is infected with HIV (Buvé et al., 2002). This has made married women extremely vulnerable who cannot negotiate for safe sex. While 140,000 Ugandans became infected with HIV in 2012, the past five years have seen an increase in the HIV infection rate, with over 65% of infections occurring amongst the married (The New Vision, 2013).

The second reservation in Article 14 (2) relates to accessibility of reproductive health services "*by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus";* Research indicates that 26% of mothers die due to abortion related causes (Guttmacher Institute, 2013), however; the state has ignored the figures and continues to criminalize unlawful abortions through The Penal Code Act (1950) thus a public denial to women of their core right, the right to life. It is quite unfortunate that a law enacted 64 years ago, which should be rendered archaic, redundant and amended to the current context continues to govern society. My field experience shows that this is the most used law by the Uganda police force.

On the one hand, the government develops strategies and programmes to reduce maternal mortality while acknowledging the gender impact on health but still rejects/does not ratify, or develop a gendered legislative framework on critical reproductive health services and empowerment of women. These double standards could be viewed as a step backwards in the promotion of human rights and gender equality. It also shows the government's failure to meet its MDG targets.

The Ugandan government needs to address maternal health and family planning/ population initiatives together. These issues should not be allowed to become single issues again, based on vertical programmes, as they were in the 1960s. The complexities involved require multi-sectoral approach and must be addressed holistically for sustainable development and equity. (Berer, 2012)

Empowerment, autonomy and improvement of women's political, economic, social and health status is pivotal in addressing the gendered inequalities and vulnerabilities existent which lead to maternal deaths. The government must be accountable to its promises to uphold human rights and gender equality. The government should advance women's reproductive and health rights and ignore notions of masculinity which assume that women cannot make correct decisions about their bodies, their fertility or health.

3.2 Early marriage and early pregnancy: impact on half of Uganda's population

An analysis of the legal and policy framework vis á vis the customary practice of early marriage will also be explored in this section of the paper. Early Marriage, often referred to as child marriage, is defined as a formal marriage or informal union before the age 18 (UNICEF, 2013). It is a reality for both boys and girls but disproportionately affects girls more severely. Recent research indicates that at least 15% of women age 20-49 were married by the time they were 15 years old and 49% were married by age 18 (Uganda Bureau of Statistics, 2012).

A large majority of rural and impoverished regions of Uganda has normalized early marriages as a longstanding tradition, rooted deeply by cultural, societal, and gender inequality which place women at the bottom of the family and social hierarchy norms dictating early marriage for girls (Paruzzolo et al., 2010). The child bride who has no say when and whom to marry, is helpless and hopeless at the mercy of her parents usually the males (UNICEF, 2013).

Early marriage is typically practiced in the context of poverty where impoverished families marry off young daughters to reduce the number of children they need to feed, and educate. Investment in a girl's education is sometimes perceived as burdensome and wastage of the inadequate family resources for a family member who will assume a new clan and family after marriage. Some families marry off daughters as an income generation strategy (see chapter 3.3).

This custom robs girls of their childhood, the option of education and is a violation of their human rights for instance the right to childhood, the right to health, and the right to choose a partner at the marriage age. The start of a menstrual period, usually before the age of 18, is the indication to her father and uncles that she is ready for marriage thrusting girls into adult roles often including forced sex and the pressure to bear children which she is not ready for/usually too young for (Amin et al., 2013).

Marriage is used as an easy target for women's bodies to perpetrate patriarchal patterns and hegemonic masculinities of male control, where men are most oppressive and women most oppressed (Washington and Tallis, 2012). She is forced to perform her reproductive roles as a wife and cannot not decide or has no say if and when to have children. The health implications for the teen mothers are enormous because their bodies often are not fully mature and are also less likely to seek adequate antenatal and post-partum care, leading to complications (Washington and Tallis, 2012). Tradition is not concerned about her rights, about her body or her health.

Maternal deaths are highest in communities with early marriage as the norm, A UNICEF press release estimates that complications from pregnancy and child birth are the leading cause of deaths (50,000) for girls aged 15-19 years in developing countries; of the 16 million adolescent girls who give birth every year, 90% are already married (UNICEF, 2013). Nigeria, where no legal minimum age of marriage exists; 25% of all women are married by age 14, 50% by 16, and 75% by 18 resulting in 14% global maternal deaths (40,000) where 30% are aged 15 and younger (World Health Organization et al., 2012).

There are commonalities to the Ugandan context. At least 24% of women age 15-19 are already mothers or pregnant with their first child. More than one-third (39%) of women age 20-49 gave birth by age 18, and more than half (63%) by age 20 (Uganda Bureau of Statistics, 2012). Early marriage often leads to childbearing at an early age and high fertility, both of which are linked to higher risk of complications in pregnancy or childbirth. It is also more likely that her child will suffer poor health outcomes (Paruzzolo et al., 2010).

Early marriage has persisted for centuries because the patriarchal system re-enforces the notions of femininity value only behind a man, a husband. Women and girls are constantly reminded that they are only visitors in their fathers homes hence not entitled to any inheritance or similar rights. This place called marriage for a young girl leaves her vulnerable to intimate partner violence than much older women, powerless to refuse sex, at risk of STD's and pregnancy. For mothers of the young brides, who dared to protect the children from the discriminatory traditions by resisting the arranged marriage, punishment is the norm (Amin et al., 2013).

Does the law seek to protect girls from early marriage?

Over the years, common justifications have been used to condone this harmful practice which upholds the notion of male control and privilege over women and girls. In Uganda, the men decide when a girl is ready for marriage and give consent to the customary union as per the Customary Marriage (Registration) Act (1973). "Customary marriage" means a marriage celebrated

according to the rites of an African community and one of the parties to which is a member of that community (1973).

Age of Marriage

Article 11 of the Act allows a girl of 16 years to marry while the marriage age for boys is 18 years. Two decades after the adoption of the Universal Declaration of Human Rights (UDHR) it is questionable whether the framers of the law intentionally chose to go against the standards of the UDHR which provides that any person below the age of 18 has a right to a childhood (UNICEF, 2013).

Article 24(3) of the Convention on the Rights of the Child (UNICEF, 1989) supports the Universal Declaration of Human Rights (1948); early marriage is prejudicial to the health of the young girl, it is a gendered discriminatory harmful practice and human rights abuse, robbing girls of their aspirations and education may abruptly be interrupted/come to an end for marriage. This renders high illiteracy and lesser opportunities for the girl child; perpetrating subordination and dependency on men consequently affecting her health seeking behaviors (Amin et al., 2013).

The Customary Marriage (Registration) Act (1973) provides no protection of girls from this horrible practice particularly the girls living in the rural communities where marriages are celebrated in accordance with customary practice/ law. It undermines international human rights standards, commitments and obligations set out in the Convention on the Rights of the Child and CEDAW both of which are ratified by Uganda. It is blind to the principle of equality between men and women, boys and girls. It is archaic, increases gendered vulnerability within the marriage and needs to be amended.

The women's movement in Uganda has for 46 years lobbied the government to pass the Marriage and Divorce Bill (2009) (see further chapter 3.3.) which seeks to revise and address the redundant and discriminatory provisions in the

current marriage laws by setting out an equitable marriageable age for boys and girls at 18 years and shifting the consent clause from the parents to the parties intending to marry in line with the Ugandan Constitution and human rights commitments/global consensus documents (2009).

Consent to marry

The Customary Marriage (Registration) Act (1973) transfers the right to consent to a marriage to parents. This right is transferred by law where, the party to the marriage is below the age of 21 years. Obviously, she has no option to refuse to marry because her non consent does not invalidate the marriage. This therefore hinders the decision of the girl to decide when to marry and thus means her sexual and reproductive roles are imposed on her at an early age. Although Article 16 (2) of CEDAW (1979) provides that, the marriage of a child shall have no legal effect; this is far from the practice in many villages in Uganda.

In a 2010 report, the CEDAW Committee urged for acceleration of the law review process to harmonize the domestic legislation with the gendered constitutional principles and obligations under the Convention relating to non-discrimination, and equality between women and men. The report also criticized the government for failing to address harmful practices such as early marriage which persist. (United Nations, 2010)

Many girls have told their unfortunate ordeals on returning home from school, only to find strangers ready to take them as a wife, she cannot report to the local authorities, because her brother or father has acted within the law which does not require her consent. This practice clearly re-enforces notions of control and ownership of women and girls in society (MIFUMI, 2012).

In 2012, while Uganda prepared to celebrate International Day of the Girl Child, U-report a free short message service (SMS) programme run by UNICEF, and the Uganda Parliamentary Forum for Children set up a poll to seek views and opinions from children and youth on ending child marriage and

teenage pregnancy. Over 80% of the 147,000 respondents knew at least one girl who got pregnant before her 18th birthday and the larger majority remembered a maternal death as a consequence (Uganda Parliamentary Forum for Children, 2012).

The traditions that perpetuate gender inequalities and women's poor status are still existent. They are driven by notions of patriarchy and history completely ignorant of the devastating effects on young women's self-esteem, bodily integrity, health or even lives. Sexual and reproductive health rights for young women and girls is not protected and prioritized. The tradition of early or forced marriage continues to cement inequalities and high risk of maternal mortality and morbidity (Paruzzolo et al., 2010).

The near missed death experience scars many child mothers for life. However, this is not an excuse to her husband. She will be forced to re-prove her fertility; she will re-live this traumatizing experience, because she is a wife, who is expected to exhibit feminine roles of bearing children. She may even be forced to have sex if she resists (see chapter 3.3). The missed education opportunity which could have reversed this cycle was denied, leaving her powerless, in an abusive marriage with no choice (UNICEF, 2013).

3.3 The culture of bride price in Uganda and its impact on gender relations and health seeking behaviour at the household level

This chapter puts the impact of bride price in a bigger context of the traditional gender relations and how that impacts women's health seeking behaviors, for example maternal health care. The practice of bride price in Uganda is widespread and accepted as the cultural norm. Bride-price consists of a contract where material items (often cattle or other animals) or money is paid by the groom to the bride's family in exchange for the bride (Hague et al., 2011). In urban areas, the practice is changing where money and goods are more commonly given in the form of non-refundable gifts, though in rural communities more traditional bride price practices remain common.

Although the past benefits of bride-price are widely recognized in Uganda, such as social harmony and improved community relations, there has been criticism about the objectives and process involved which re-enforces gender norms around masculinity and femininity. A society where women accordingly assume inferior and servile social roles excluded from centers of male gendered power.

The custom of haggling and bargaining a price objectifies women, worsening their subservient position in a traditional patriarchal setting that cements/perpetrates gender inequality and their subordinate status in society. This practice allows hegemonic masculinities to manifest their power through the ability to pay for the bride. If he cannot afford to pay, uncles and clan leaders quickly become involved to prove to the bride's family that he is a man who will be able to be the bread winner. For many developing countries including Uganda, the breadwinner ideology is characteristic of hegemonic masculinities (Groes-Greene, 2009).

The process often associated with accumulation of wealth involves discussions between "men". There is no consideration for female headed households or where the bride's father has died. Wealth and resources are not topics women can dare be part of, because a woman cannot be seen at the meeting of "men". The payment guarantees less decision making powers for the woman; historically, a bride was viewed as commodity to be passed from family to family until human rights activists criticized this practice for increasing the spread of HIV prevalence particularly among married women (see chapter 3.1), thus; promoting male dominance in society and vulnerabilities for women (Thiara and Hague, 2009).

With reduced household decision-making roles, limited independence and low self-esteem, a woman cannot make any decisions or choices without the consent of her husband. He has absolute control/rights over her, including the right to have sex whenever he pleases, the right to decide if she must access family planning services or health care (Uganda Bureau of Statistics, 2012).

Her feminine roles are emphasized in marriage to compensate for the cows and goats exchanged for her hand in marriage. Where a woman insists on making decisions related to sexuality, for instance on condom use, spacing of children, it raises suspicion of sexually transmitted infections, unfaithfulness and questions his manhood on his ability to produce. Society will be quick to blame and judge the woman for being a "bad wife"(Jacobson, 2000)

The health burden /cost could be life threatening, but many women suffer in silence because for society, this normal; "business as usual" as discussed earlier in this paper which often leads to miscarries, severe disability and ill health or even death. She cannot leave her abusive marriage, often reminded by her paternal aunt that she is lucky to be married. She must endure because it's a woman's nature to endure and forgive and not embarrass her husband. Her bride price was paid, and used to marry a wife for her brother and she would have to refund it if she left the marriage, which she cannot afford (MIFUMI, 2012). A few years ago, one of the Ugandan local dailies (the Daily Monitor), ran a story; a devastating account, highlighting the subordinate role of the woman/wife and complete control over her life. *"Nathan Awoloi forced his wife, Jennifer Alupot, to breastfeed puppies because he claimed not to have any cows left to do so, after giving them to her family as part of her "bride price". Her third child, who she was also breastfeeding at the time, had since died of suspected rabies."*

The process involved in the practice of bride price has lived its relevance. Mary Wallstonecraft, a philosopher, back in 1792 wrote **"…we need to challenge traditions that are not justifiable".** We cannot continue to lose 6000 women annually giving birth and; we cannot continue to see men abuse their powerful positions to cement gender inequalities. It is the current reality that women's roles and rights are still undervalued and not recognized in Uganda.

There are devastating accounts of women who have failed to leave these dehumanizing and abusive marriages because of the conditions imposed upon them, such as, not being able to leave with their children because the children

traditionally belong to the man and they are required to pay back the bride price first (Kaye et al., 2005). Many women will stay to protect and fend and support their children. The documentary *'What Price, Bride Price'* shows for Uganda the consequences that setting a price for the bride has during her marriage. For many women, marriage is a prison where all rights are stripped away, all dignity is lost and one´s mere existence is for her children.

The growing concern among human rights/ women´s rights activists in the country about the negative impacts of bride-price especially on women, children, family life and community development led to the filing of a court petition by MIFUMI project, a local organization to challenge this custom which seems to have lost its purpose, probably the battle can be won to end this inhuman practice and end this sad reality for many women and girls especially in the rural areas.

The Judicial Court Ruling on bride price

In March 2010, a four-to-one majority decision in the Ugandan Constitutional Court rejected a petition for abolishing the traditional practice of bride price (dowry) in Uganda (Nsambu, 2010). Why should a practice that was relevant 50 years ago, still continue to exist with all its flaws? Did the justices contribute to cementing gender inequalities through rejecting the petition? Activists were disappointed with the judgment of Lady Justice Laetitia Kikonyogo, the Deputy Chief Justice of the Court, then, who wrote in her judgment …*"although the practice occasionally results in domestic abuse and mistreatment of women, that fact alone is not sufficient to compel the Court to make a general prohibition of the practice."*

This is a clear indication of the failure of legal systems to protect women's human rights, the institution who many regard to uphold the highest standard failed to address their minds to the realities of many women. Who will protect them, who will make their plight end?

Although Justice Amos Twinomujuni, the only dissenter, argued that the practice has *"become purely commercialized, highly exploitive and humiliating to women, and went as far as equating the practice to slavery,"* his decision was a minority. However, the judges agreed that the practice of requiring a woman to pay back bride price in the event of dissolution of a marriage is unconstitutional, because it dehumanizes the woman and undermines a wife's unique and valuable contributions to a marriage. The non-monetary feminine roles are often not recognized. Unfortunately, this positive aspect of their ruling seems not to be enforced or widely known among the rural communities.

It is clear that the practice violates several articles of Uganda's 1995 Constitution including the constitutional right for a man and woman to enter a marriage with free consent. This principle of consent is compromised when the bride's family demands a bride price in exchange for their daughter and/or when the husband demands a refund for the bride price if the wife wants a divorce.

The constitutional right to equality, the right to be free from sex discrimination, and the right to be treated with dignity is also abused because with payment of bride price, she is treated as a possession" (Goitom, 2009).

The Marriage and Divorce Bill

Women have not lost hope. Advocacy for the 46 year old pending Marriage and Divorce Bill (2009) which compliments the provisions in CEDAW and Article 21 (1) of the Constitution is still high on the women's rights/movements agenda. The Bill promotes equality and freedom from discrimination for all under the law in all spheres of political, economic, social and cultural life and in every other respect.

The Bill seeks to change the mandatory requirement of bride price will help women to break free of the slavery that her family norms and traditions have created. Recognizing marriage gifts as a non-essential requirement for marriage will allow the non-exchange to be valid; it will not involve haggling

and setting a price for the bride and will seek to reduce the commercialization trend today, which questions the objective of the practice (Uganda Women's Network, 2010).

The Bill also criminalizes the demand for the gifts upon dissolution of the marriage which will allow many women regain their self-consciousness, feel equal partners and in the marriage and consequently, equality, dignity and respect of rights including the right to choose the number of children, spacing, when to have sex, and improved maternal health outcomes. While the Bill seems to be one of the policy amendments which is highly anticipated by women, it has support from the speaker of Parliament and key female decision makers in Uganda's cabinet, who are pushing its agenda. It is quite notable that it is women in leadership positions advancing the Bill. Where are the men?

The current 9th Parliament managed to pass 20 clauses until the male legislators, cultural and religious leaders who are not ready to recognize women autonomy and control over their sexuality strongly opposed the Bill. They petitioned the president who influenced its being shelved pending further consultations. The only hope that women of Uganda still have, is that the Bill continues to remain on the order paper-agenda of Parliament.

The Maputo Protocol

Article 5 reaffirms and calls upon State Parties such as Uganda to prohibit and condemn all forms of harmful practices, which negatively affect the human rights of women, and which are contrary to recognized international standards. While Uganda is counted among the countries that ratified and domesticated the protocol in 2010, these commitments are not translated to action.

Women's issues rarely receive a lot of support or prioritization by the State and the national gender machinery, Ministry of Gender, Labour and Social Development receives a meager percentage of the country's national budget. A lot of the efforts towards implementation of the protocol have come from the

international community and NGO's operational within the country. Women's issues are often overlooked until a TMB requires or demands for progress. This is inexcusable.

The Ugandan state/government has failed to honor constitutional and human rights obligations to protect the countless number of girls and women who are battered because of the price paid, who are not considered as equal human beings and whose rights especially sexual and reproductive rights are ignored leading to 16 mothers dying while giving birth every day in Uganda. The government has no excuse for not meeting the needs of more than half of Uganda's population. The devastating consequences of the process and practice are real and must be put to a stop.

4. Recommendations and Conclusion

Applying a rights framework to the policy and investment efforts for sexual and reproductive health does not only protect and advance human rights, health and wellbeing of individuals, but ensures women´s empowerment, enormous society benefits, national economies and sustainable development. Gender approaches need to be integrated within a human rights framework to ask the critical questions e.g. what is the issue, what is the cause of the issues, what can and should be done to address the issue?

The programmes and policies on sexual and reproductive health referred to in this paper, seem to have been developed within the welfare approach (Peet and Hartwick, 2009) which viewed women as mothers and housewives while men seen as the agents and actors of development. Obviously, this has not achieved significant results; for example, the unmet need for contraception remains high, because the cultural structures favor men and disempower women impacting on women's health seeking behaviors. Societies where women have been reminded from childhood that a women's sense of worth, power and mastery comes from being a traditional wife who must fulfill one of her primarily assumed feminine roles, child bearing. These programmes in Uganda failed to address the critical issues as described by Millet in *Sexual Politics*

(1970) *"the roots of oppression are buried in the gender system/sex where women have no say at all, and if she acts "uncontrollably", she may be subjected to cruelties or punishment".*

Furthermore, the absence of institutional and enabling policy environments that comprehensively promote, support and protect sexual and reproductive health rights is an important obstacle often ignored. This paper has drawn inferences while acknowledging that the global level policy wins need to urgently trickle down to country level. The international frameworks have integrated a human rights and Gender and Development (GAD) approach incorporating efforts to address gender relations and power, and emphasizing on outcomes. It asserts social justice and individual rights be prioritized at the center of programming and policy (Jacobson, 2000). This approach requires society and systems valuation of the feminine as much as the masculine cognizant of the different practical and strategic needs for men and women as a heterogeneous group (Tong, 2009)

As much as the policy framework is critical and gives a foundation for accountability and commitment of the Ugandan government towards eliminating practices that discriminate against women or impede women's ability to exercise their sexual and reproductive health and rights, this unfortunately will not address the issue independently if budgets are not allocated. Gender budgeting and mainstreaming for women's reproductive health is an important approach at policy development and programming level. Policy makers need to stop viewing women's health as "business as usual" and not a popular imagination requiring significant investment (Correˆ et al, 2005).

It is important to note that even with a budget, political and enabling environment; there is a lot that still needs to be done. The laws and policies cannot fully address poor maternal concerns if the health systems are not strengthened, if women do not have education, if there are no health facilities for delivering among others, This paper provides a legal lens, gender and human rights perspective to only one of the main obstacles. The struggle is

huge and requires a holistic approach for Uganda to reduce its maternal deaths.

The integration of a human rights framework with contextual gender approaches for Uganda will ensure a sense of entitlement among the health seekers both men and women. It will tackle the unequal gender relations deeply rooted in social, cultural and patriarchal patterns which violate women's human rights. That time has come for the customs that promote inaccessibility to universal family planning, customs which support early marriage and negative norms of bride price that are discriminatory to be outlawed as emphasized in 1972 by Mary Wallstonecraft in *Vindication of the right of woman.*

Civil society organizations (CSO's) should heighten advocacy and monitoring efforts aimed at advancing women's sexual and reproductive health rights by publically demanding the government for implementation of a human rights and engendered implementation strategy. The CSO's should continue to put pressure on the government by submitting shadow reports, individual communications to UN TMBs, and engaging with the Universal Periodic Review process of the Human Rights Council to demand for progress from Uganda.

While this paper has indicated some progress towards addressing sexual and reproductive rights concerns such as maternal mortality for Uganda, it is clearly not on track with fulfilling its obligations to the women and meeting its MDG-5 targets. 16 women continue to die daily while giving birth (Uganda Bureau of Statistics, 2012); this is very unfortunate for a country that agreed to the ICPD Programme of Action which recognizes that increasing women's ability to survive pregnancy is an issue of their being "equal in dignity and rights". If women are to be equal, governments have at least the same obligation to prevent maternal death, one of the implications of sexual and reproductive health and rights violations, as to prevent death from ill-health and disease. In fact, given that maternity, the sole means of natural human

propagation, is not a disease, equity requires more protection against the risk of maternal mortality than against death from disease. (United Nations, 1994)

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Annex

Annex 1: Regional and International Treaties, conventions and agreements relevant to reproductive health and rights

(The State World Population report, 2012)

These important instruments provide support to the regional and international legal framework referred to in this paper.

1948, Universal Declaration of Human Rights: A key document that has inspired the whole human rights discourse and many constitutions and national laws, and a source of international customary law
1968, Tehran Conference on Human Rights proclaims and declares the right of individuals and couples to information, access and choice to determine the number and spacing of their children.
1976, International Covenant on Civil and Political Rights, which is used by civil rights groups in their fight against government abuses of political power.
1976, International Covenant on Economic, Social and Cultural Rights adopted in 1966 and entered into force in 1976. Article 12 of the Covenant recognized the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
1979, The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) is the only international human rights document that specifically references family planning as key for ensuring the health and well-being of families. CEDAW provides the basis for realizing equality between women and men by ensuring women's equal access to, and equal opportunities in, political and public life—including the right to vote and to stand for election—as well as education, health and employment.
1989, Convention on the Rights of the Child sets standards for the defense of a child against neglect and abuse in countries throughout the globe. In order to protect the best interests of the child, it aims to: protect and ensure the right of

children to have access to certain services, such as health care and information on sexuality and reproduction. Guarantee the participation of the child in matters concerning his or her life as s/he gets older. This includes exercising the right of freedom of speech and opinion.
1993, United Nations World Conference on Human Rights in Vienna affirmed women's rights are human rights.
1994, At the International Conference on Population and Development (ICPD) in Cairo, 179 governments agreed that population and development are inextricably linked, and that empowering women and meeting people's needs for education and health, including reproductive health, are necessary for both individual advancement and balanced development. Concrete goals of the ICPD centered on providing universal access to education, particularly for girls; reducing infant, child and maternal deaths; and ensuring universal access by 2015 to reproductive health care, including family planning, assisted childbirth and prevention of sexually transmitted infections including HIV.
1995, Beijing Declaration and Platform for Action , United Nations Fourth World Conference on Women Reiterates broad definition of right to family planning laid out in ICPD Programme of Action.
2000, The Millennium Development Goals (MDGs). The goals are a road map with measurable targets and clear deadlines; the targets relevant to reproductive health include: • Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio (MDG-5). • Achieve, by 2015, universal access to reproductive health (MDG 5-B).
2003, The Protocol to the African Charter on Human and People's Rights on the Rights of Women also known as the Maputo Protocol or the African Women's Protocol was adopted by the African Union (AU) on July 11, 2003 at

its second summit in Maputo, Mozambique. The Protocol guarantees comprehensive rights for women including sexual and reproductive health. To date, only four countries (Botswana, Egypt, Eritrea, and Tunisia) have not yet signed the Protocol.
2004, The 57th World Health Assembly adopted the World Health Organization's first strategy on reproductive health, recognized the Programme of Action and urged countries to implement the new strategy as part of national efforts to achieve the MDGs. •Make reproductive and sexual health and integral part of planning, budgeting as well as monitoring and reporting on progress towards the MDGs. •Strengthen health systems to provide universal access to reproductive and sexual health care, with special attention to the poor and other marginalized groups, including adolescents and men.
2005, World Summit 2005, follow-up to the 2000 Millennium World Summit. World leaders committed to universal access to reproductive health by 2015, to promote gender equality and end discrimination against women.
2010, MDG/10 Review Summit. World leaders renewed their commitment to universal access to reproductive health by 2015 and promote gender equality and end discrimination against women.
2011, The Committee on the Elimination of Discrimination against Women issued a decision establishing that all States have a human rights obligation to guarantee women of all racial and economic backgrounds timely and non-discriminatory access to appropriate maternal health services.

Annex 2: Status at a Glance of Uganda's Progress towards the MDGsImproving (Ministry of Finance Planning and Economic Development, 2010a)

Goal 1: Eradicate extreme poverty and hunger	
Target 1.A: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	ON TRACK
Target 1.B: Achieve full and productive employment and decent work for all, including women and young people	NO TARGET
Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	ON TRACK
Goal 2: Achieve universal primary education	
Target 2.A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	SLOW
Goal 3: Promote gender equality and empower women	
Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	ON TRACK
Goal 4: Reduce child mortality	
Target 4.A: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate	SLOW
Goal 5: Improve maternal health	
Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	SLOW
Target 5.B: Achieve, by 2015, universal access to reproductive health	SLOW
Goal 6: Combat HIV/AIDS, malaria and other diseases	
Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	REVERSAL
Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it	ON TRACK
Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	SLOW
Goal 7: Ensure environmental sustainability	
Target 7.A: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	SLOW
Target 7.B: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss	SLOW
Target 7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	ON TRACK
Target 7.D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	NO TARGET
Goal 8: Develop a global partnership for development	
Target 8.B: Address the special needs of the least developed countries	REVERSAL
Target 8.D: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	ACHIEVED
Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	STAGNANT
Target 8.F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	ON TRACK