

# Universal Periodic Review of Republic of Uganda 26<sup>th</sup> Session

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*Joint submission by:*

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**KEY WORDS:** Health sector expenditure, maternal mortality, unsafe abortion, human immunodeficiency virus, acquired immunodeficiency syndrome, sexuality, sexual and reproductive health, and female genital mutilation.

## **EXECUTIVE SUMMARY**

This submission elaborates progress made by the Government of Uganda over the last four and half years on specific recommendations emanating from the first cycle of the Universal Periodic Review in 2011, and identifies the gaps and the challenges that need to be addressed.

First, the government has not managed to meet the 15 per cent Abuja Declaration target for health sector expenditure as a percentage of the total government expenditure. The expenditure has been fluctuating since 2010/2011 with an average of 8.4 per cent budget allocation over the five years. As a result the challenge of inadequate and in some cases poor sexual and reproductive health service delivery has persisted because of inadequate budgetary allocation.

Second, the maternal mortality ratio is still high because of delays by government institutions in providing timely and appropriate care, relevant emergency medicines and supplies, basic equipment and supplies for conducting normal deliveries and providing antenatal care for pregnant women. The national met need for emergency obstetric care is only 40 per cent and yet about 15 per cent of all pregnancies develop life-threatening complications and require emergency obstetric care, in early and late pregnancies. Other drivers of maternal mortality are unsafe abortions because of a restrictive legal framework.

Third, Uganda has a high number of people living with HIV and is still classified as a high burden country. The key drivers of HIV incidence are failures at policy level in terms of providing sexuality education, and in service delivery with regard to timely supply of anti-retroviral drugs to persons living with HIV and AIDS.

Finally, even though duty bearer awareness that female genital mutilation is illegal increased with the enactment of the Prohibition of Female Genital Mutilation Act in 2010, implementation and enforcement of the Act has been weak. This is evidenced by the fact that the biennial practice has clandestinely persisted in parts of north-eastern Uganda. Since the enactment of the law there has only been one case where perpetrators were arraigned, successfully tried and sentenced in a court of law.

## INTRODUCTION

1. The Government of Uganda submitted its national report to the 12<sup>th</sup> session of the Universal Periodic Review (UPR) in July 2011, in accordance with Human Rights Council resolution 5/1. This submission elaborates progress made over the last four and half years, in terms of implementation of specific recommendations emanating from the 1<sup>st</sup> Cycle of the UPR in 2011, the gaps and the challenges that need to be addressed in the 2<sup>nd</sup> Cycle beginning 2016.

2. The prioritised recommendations for action by the Government of Uganda on sexual and reproductive health and rights thematically are: a) Health sector expenditure for improved sexual and reproductive health services; b) Maternal mortality and care; c) Prevention, care and treatment of HIV/AIDS, and d) Elimination of harmful traditional practices.

### A. HEALTH SECTOR EXPENDITURE FOR IMPROVED ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES

#### Universal Periodic Review Recommendations: Progress and Gaps in Implementation

3. Uganda received and accepted a recommendation to increase access to sexual and reproductive health services by raising the health budget to 15 per cent, in line with the Abuja Declaration, 2001 in which the African Heads of State pledged to set a target of allocating at least 15 per cent of their respective annual budgets to improve the health sector.<sup>1 2</sup>

4. Currently the health sector is financed through government revenue and development assistance support under the sector-wide approach and whereas, since 2011 the Government has steadily increased its budget allocation to the health sector, it continues to allocate less than 10 per cent of the national budget to the sector. Government allocation as a percentage of the total national budget has averaged about 8.4 per cent from financial year (FY) 2010/11 to 2013/14.<sup>3</sup> Notwithstanding, in FY 2013/2014 the budget was raised to Uganda Shillings 1,127.4 billion; this was 8.6 per cent of the national budget, while in FY 2014/15 the budget was increased to Uganda Shillings 1,281.130 billion.<sup>4</sup> In FY 2015/2016 the health sector budget was actually reduced to Uganda Shillings 1,220.97 billion, which was a 4.7% drop. Specifically with regard to reproductive health funding the recurrent budget allocated to reproductive health increased from Uganda Shillings 143 million in FY2011/12 to Uganda Shillings 267 million in FY2013/14, making it an 87 per cent increase.

#### Background

5. The Constitution of Uganda (1995) stipulates that the State shall endeavour to fulfil the fundamental rights of all Ugandans to social justice and economic development by ensuring access to health services, among other rights. The development of the second National

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<sup>1</sup> World Health Organisation *The Abuja Declaration: Ten Years On* Available at: <http://www.who.int/healthsystems/publications/Abuja10.pdf> Accessed: 12 March 2016

<sup>2</sup> UPRWG Report: Paragraph 111.92 page 20 (Recommendation by Belgium) – “Create a health insurance scheme for the poor” However, the recommendation as read during the interactive dialogue “Increase access to sexual and reproductive health services by raising the health budget to 15 per cent in line with the Abuja declaration and by creating a health insurance scheme for the poor”

<sup>3</sup> Ministry of Health Annual Performance Report FY 2013/2014

<sup>4</sup> Health Ministerial Policy Statement 2015/2016 Sector Budget Allocations p. xxiii

Health Policy was informed by the National Development Plan I (2010/11-2014/15), and the 1995 Constitution.<sup>5</sup> The National Development Plan specifically places emphasis on investing in the promotion of people's health and nutrition, which constitute a fundamental human right for all, and on priorities that strengthen health systems. The policy also emphasises the efficient use of available health resources, for example in health infrastructure, human resources, medicines and health supplies and health financing, the effective delivery of the Uganda Minimum Health Care Package, and strengthening public and private partnership for health.

### **Problem Identification**

6. Health services in Uganda are delivered within the decentralization policy and legal framework. The district local governments' plans oversee service delivery within the district and receive the bulk of the funding, which is approximately 50 per cent of the health sector budget from the central government, in form of conditional grants. They also receive considerable off-budget support from development partners as project funds.<sup>6</sup> Whereas the government committed to take all necessary measures to ensure that the needed resources, both financial and human, are made available from all sources, the health sector budget is still well below the 15 per cent target, with much of the funding being off-budget and funded by development partners.

7. Government health expenditure as a percentage of the total government expenditure has been fluctuating since 2010/2011 with an average of 8.4 per cent over the five years. The variation in the percentage expenditure has been on account of increasing total health expenditure but with some sectors like the energy sector and the roads sector getting a relatively bigger share of the increase in budget allocation. For example, the general public administration sector and the roads sector, took the largest share of the recurrent and development expenditure, in FY 2011/2012, accounting for 48.1 per cent and 44.5 per cent respectively. This was followed by defence which took 15.3 per cent of recurrent expenditure.<sup>7</sup> The health sector budget remains largely under-funded by the Government and therefore inequitable. Furthermore, even though health care is a fundamental human right it is not being accessed by everybody irrespective of income.

8. Whereas the minimum recommended per capita health care funding is USD 35 per annum, the per capita health care funding was roughly USD 13.7 under public health financing in FY 2014/15.<sup>8</sup> The underfunding of the health sector as a whole persists and was one of the reasons why the MDG target on improving maternal health (MDG 5) was not realized by 2015. This has meant that sexual and reproductive health services have failed to result in full enjoyment of sexual and reproductive health and rights in the country, especially by women and girls. Resource mobilization in terms of financing the health sector, and for sexual and reproductive health services as whole, remains a challenge for the Government.

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<sup>5</sup> The Committee on Economic, Social and Cultural Rights and the Committee on the Elimination of Discrimination against Women (CEDAW) have both clearly indicated that women's right to health includes their sexual and reproductive health.

<sup>6</sup> Ministry of Health Uganda Health System Assessment Report 2011 p. 9 Donors include USAID, DFID, DANIDA, EU, GAVI, Austria, Global Fund, Ireland, Austria, WHO, World Bank, UNICEF, UNFPA and Sweden.

<sup>7</sup> Uganda Bureau of Statistics Statistical Abstract 2014 p.74-75

<sup>8</sup> Ministry of Health Annual Health Sector Performance Report FY 2014/2015 p.18

9. The problem of inadequate and in some cases poor sexual and reproductive health service delivery because of inadequate funding is national. However, the people most affected are the women and girls in the conflict affected parts of the northern region of Uganda where the human development index at 0.394 continues to remain much lower than the national average of 0.463.<sup>9</sup> Whereas Government recovery plans, including the Peace, Recovery and Development Plan (PRDP 1 & II) have tried to address the infrastructural challenges such as construction of Health Centre III and IV in districts most affected by armed conflict, inadequacy and/or absence of human resources and equipment, and lack of requisite skills in the health centers for them to actually become fully functional, remain a challenge.<sup>10</sup> The issues of capacity and staffing are major hindrances to the ability to provide essential services, and many health centers are not functional because of the failure to both attract and retain qualified and motivated staff.<sup>11</sup>

### **Recommendations**

10. The Government should progressively increase the resource envelope for the health sector in its Medium Term Expenditure Framework, and also increase the expenditure ceilings in annual Budget Call Circulars.

11. The Government should mobilise more resources locally to finance the national budget, and specifically the health sector budget by improving tax administration and enhancing tax revenue, including broadening the tax base.<sup>12</sup>

12. The Government should ensure that the Ministry of Health strengthens its management of public finances for increased and better access to sexual and reproductive health services.

## **B. MATERNAL MORTALITY AND CARE**

### **Universal Periodic Review Recommendations: Progress and Gaps in Implementation**

13. The selected recommendations were: (i) improve health indicators, and particularly decrease maternal mortality rates (MMR), which remained short of the 2015 Millennium Development Goals (MDG) target, and (ii) consolidate on-going actions to reduce maternal mortality. Both recommendations were accepted.<sup>13</sup> In 2011 the MMR stood at 438/100,000 live births.<sup>14</sup> This was still higher than the MDG target of 131/100,000 live births.<sup>15</sup> However, the World Health Organisation (WHO) figures put the MMR estimation at 343/100,000 live births in 2015,<sup>16</sup> while the National Development Plan II (2015/16-2019/20) puts the figure at about 438 per 100,000 live births.<sup>17</sup> Nonetheless, the Government maintains that there is

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<sup>9</sup> UNDP Uganda Human Development Report 2015 *Unlocking the Development Potential of Northern Uganda* p. 26

<sup>10</sup> UNDP <sup>10</sup> Uganda Human Development Report 2015 p. 52

<sup>11</sup> *Ibid* p. 54

<sup>12</sup> Addis Ababa Action Plan 2015 II Action Areas, A. Domestic Public Resources (20) p.5

<sup>13</sup> UPRWG Report: Paragraph 111.91 & 111.90 page 20

<sup>14</sup> Uganda Demographic and Health Survey 2011

<sup>15</sup> MDG Country Assessment Report, 2013

<sup>16</sup> WHO, UNICEF, UNFPA, World Bank Group, and United Nations Population Division Maternal Mortality Estimation Inter-Agency Group Maternal mortality in 1990-2015

<sup>17</sup> National Development Plan II (2014/2015 – 2019/2020) p. xxiii

a general decline in average annual ‘health facility based’ maternal deaths from 194/100,000 live births in 2010/11 to 146/100,000 live births in 2013/14.<sup>18</sup>

14. A major challenge and gap in sexual and reproductive health care service provision is the functionality of hospitals and health centres with regard to equipment and supplies. The Government’s response to the challenge of inadequate equipment and supplies for maternal health care has been the *Uganda Health Systems Strengthening Programme* (Project 1123) which commenced implementation in May 2010 and ended July 2015. It was aimed at reducing maternal mortality and was set to enhance physical functionality of health facilities by renovating health infrastructure and providing medical equipment, among other objectives including strengthening provision of reproductive health services to reduce maternal and pre-natal death through provision of emergency obstetric care and new-born care equipment. Two regional referral hospitals, 17 general hospitals and 27 Health Centre IV benefitted from the project.<sup>19</sup>

15. Other strategies and actions to reduce the MMR included advocacy and the institution of mandatory maternal death notification and reviews by all health facilities. The Ministry of Health and its partners are also training health workers, particularly midwives, distributing delivery kits called ‘Mama Kits,’ and supporting voluntary family planning services, and providing sexuality education.<sup>20</sup>

## **Background**

16. The Constitution recognizes the need to protect the maternal functions of women, including reproduction. Article 33(3) states, “The State shall protect women and their rights, taking into account their unique status and natural maternal functions in society.” This provision recognizes that women have rights that arise from their maternal functions thereby implicitly placing obligations upon the State to protect the sexual and reproductive health and rights of women. Under the Penal Code Act (Cap 120) as amended through the Penal Code (Amendment) Act 2007, Sections 141-143 and 212 and Cap 224, where abortion is only permitted in cases of saving the life of a woman, and preserving physical health and mental health and is regulated by the Standards and Guidelines for the Reduction of Maternal Mortality and Morbidity due to unsafe abortion, launched in 2015.

17. The National Health Policy has set maternal and reproductive health care as one of the priority areas. Reduction of maternal morbidity and mortality are key outcomes expected, while safe motherhood is among the key elements of the Minimum Health Care Package. The National Population Policy Action Plan (2011-2015) seeks to improve availability and accessibility to comprehensive sexual and reproductive health services at all levels.<sup>21</sup> The Adolescent Health Policy (2004) seeks to reduce lifetime risk of maternal death in age group 15 to 24 years, first childbirth delayed/reduced, mothers below 20 years delivering in a health facility and increase the proportion of adolescents that are knowledgeable about sexually transmitted infections and AIDS.<sup>22</sup>

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<sup>18</sup> Ministry of Health Sector Annual Monitoring Report FY 2013/2014

<sup>19</sup> Ministry of Finance Planning and Economic Development Health Sector Annual Monitoring Report Financial Year 2013/14 October 2014 p.11

<sup>20</sup> Joan Kabayambi *Global Trends in maternal mortality: How does Uganda fare?* Available at:

<http://www.cehurd.org/2014/06/global-trends-in-maternal-mortality-how-does-uganda-fare/> Accessed: 20 January 2016

<sup>21</sup> National Population Policy Action Plan 2011-2015 p.17

<sup>22</sup> Adolescent Health Policy (2004 ) p.15-16

## **Problem Identification**

18. The association of unsafe abortion with high levels of maternal mortality and morbidity is linked to the failure by the State to provide health services, including reproductive services. The proportion of facilities providing appropriate emergency obstetric care is still low and so is access to postnatal care within first week of delivery, which stands at 26 per cent. About 15 per cent of all pregnancies develop life-threatening complications and require emergency obstetric care, in early and late pregnancies. The national met need for emergency obstetric care is only 40 per cent.<sup>23</sup> In addition, the proportion of pregnant women delivering in government and private facilities is still low at 44.4 per cent in 2013/2014 (with a target of 48 per cent for 2015/2016).<sup>24</sup> Furthermore, only 11.7 per cent of women deliver in fully functional comprehensive emergency obstetric care facilities. The main causes of maternal deaths are haemorrhage, sepsis, obstructed labour, unsafe abortion and hypertensive disorders in pregnancy.

19. The main factors responsible for maternal deaths relate to the delay by duty bearers to provide timely and appropriate care; failure by the government medical procurement and distribution agency to supply relevant emergency medicines and other essential supplies including blood at the endpoint of referral and to ensure the supply of basic equipment and supplies for conducting normal deliveries, and essential equipment and supplies for basic antenatal care for pregnant women, and for unsafe abortions. Another factor responsible for maternal deaths is unsafe abortions. According to the Uganda Demographic and Health Survey (2011), 26 percent of the maternal mortality ratio (438 per 100,000 live births), is attributed to unsafe abortions. This is because of a legal framework that only permits abortions where the life of the woman is threatened, or where physical health, or mental health is at stake.

20. The referral mechanism has also faced challenges of poor road networks in some of the 'hard to reach' areas, and insufficient funding for operating and maintenance of ambulances.<sup>25</sup> Only one-third of facilities offering maternal delivery services have basic equipment and supplies for conducting normal deliveries and less than one-quarter of health facilities have all the essential equipment and supplies for basic antenatal care for pregnant women.<sup>26</sup>

## **Recommendations**

21. Government should allocate more resources for capital expenditure to expand the 'health systems strengthening programme' in order to improve the functionality of the hospitals and health centres and should expand infrastructure coverage and functionality in the 'hard-to-reach' parts of the country.

22. Government should use the resources mobilized to secure essential equipment, drug supplies and trained medical personnel for provision of emergency obstetric care, maternal and new born care services in the hospitals and health centres to reduce the maternal mortality ratio.

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<sup>23</sup> Ministry of Health Sector Strategic and Investment Plan, *Promoting People's Health to Enhance Socio-economic Development (2010/11–2014/15)*

<sup>24</sup> Ministerial Policy Statement FY 2015/2016

<sup>25</sup> Ministry of Health Sector Strategic and Investment Plan

<sup>26</sup> World Health Organisation Geneva 2014

23. Government should expand the circumstances under which safe abortion is legal and services sought, to include cases of sexual assault, rape, and incest, as stipulated in the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, Article 14, *Health and Reproductive Rights*, Section 2 c).<sup>27</sup>

## C. PREVENTION, CARE AND TREATMENT OF HIV/AIDS

### Universal Periodic Review Recommendations: Progress and Gaps in Implementation

24. Another UPR recommendation was for the Government to continue to work with the WHO and other relevant international agencies to further reduce the prevalence rate of HIV/AIDS and enhance access to quality health services for its people.<sup>28</sup> The Government accepted the recommendation and has since strengthened its partnership with development partners including several UN agencies to reduce the prevalence rate and to enhance access to quality health services. The Government has continued working with development partners who established the AIDS Development Partners Group (ADPG), a working group that includes WHO, the World Bank and other bi-lateral agencies.<sup>29</sup> The aim of the ADPG is to work for a more effective harmonisation and coordination of development efforts against the spread of HIV/AIDS aligned with government priorities and plans. Financial and technical support was mobilized to contribute to the reduction of new HIV infections, as well as provision of care and treatment and social support for those affected by HIV/AIDS.<sup>30</sup>

25. In 2014, in response to the Abuja Declaration, a review of Uganda's national response was undertaken, implementation intensified and resource mobilization initiated.<sup>31</sup> This resulted in increased uptake of HIV prevention, treatment and care services thus facilitating reduction in the number of new HIV infections among adults and children, and in the number of AIDS related deaths. In terms of prevention, a package of combination interventions were implemented in the country resulting in HIV/AIDS counseling and testing being scaled-up with more people accessing services compared to 2013. There has been sustained expansion of the national *Eliminating Mother to Child Transmission Programme* resulting in about 95 per cent of pregnant HIV positive mothers accessing anti-retroviral (ARV) drugs, and a reduction in the number of babies born HIV positive by end of 2014. There has also been intensified condom programming with the endorsement of a comprehensive condom programming strategy and increase in number of condoms distributed from 187 million condoms in 2013 to about 230 million condoms by the end of 2014.<sup>32</sup>

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<sup>27</sup> Saturday Monitor March 15 2016 "Government drafts new law to okay abortion... in some instances" Available at: <http://www.monitor.co.ug/News/National/Government-drafts-new-law-to-okay-abortion/-/688334/2812390/-/egyrxu/-/index.html> Accessed: 12 March 2016

<sup>28</sup> UPRWG Report: Paragraph 111.88 page 20

<sup>29</sup> The European Union, the Department for International Development (DFID), the Danish Agency for Development Assistance (DANIDA), the Swedish Development Cooperation Agency (SIDA), Irish Aid, USAID, and the Italian, Dutch, German, French and Japanese governments.

<sup>30</sup> The Uganda HIV/AIDS Country Progress Report, 2014

<sup>31</sup> Abuja Declaration on HIV/AIDS, tuberculosis and other related infectious diseases. April 2001

<sup>32</sup> Uganda HIV/AIDS Country Progress Report 2014

## Background

26. Uganda has a National AIDS Policy and HIV Counselling and Testing Policy that directly respond to the impact created by HIV/AIDS. The country also adopted the Anti-Retroviral Therapy (ART) Guidelines in 2013 for increased access to ART services and HIV prevention. The HIV/AIDS Prevention and Control Bill was also enacted in 2014 and provides for penalties and sanctions for discrimination on the grounds of one's HIV status, in all spheres of life, and legislates access to health care services, with health institutions whether public or private being responsible for assisting persons who acquire HIV to access treatment. Under the Act the State is also obliged to devise measures to ensure the right of access to equitable distribution of health facilities, goods and services including essential medicines in a non-discriminatory manner, and provide treatment to all persons in a non-discriminatory manner.

## Problem Identification

27. Uganda is still classified as a high burden country with high number of the population living with HIV, which has continued to increase. The national projections indicate an increasing number of people living with HIV; 1.4 million in 2011 to 1.6 million in 2013, and with a drop to 1.5 million in 2014 and high number of orphans due to AIDS related deaths totalling about 1 million.<sup>33</sup> AIDS related deaths have increased the care burden of women and girls, but especially older persons who also end up taking care of orphans.

28. The key drivers of HIV incidence rate are failures of policy and service delivery.<sup>34</sup> The absence of a comprehensive sexuality education policy framework and curriculum that goes beyond abstinence and includes content on safer sex practices contributes to the higher HIV prevalence rate among not only adolescents, but also sex workers, men having sex with men and other marginalised groups. HIV prevalence is highest for women in parts of northern Uganda, because of the insurgency.<sup>35</sup> In terms of failures in service delivery in 2014 the media reported ARV stock-out in certain districts which the Government attributed to distribution challenges by National Medical Stores.<sup>36</sup> Furthermore, female condoms are not subsidized by Government and are therefore inaccessible to a majority of women because of the high cost.

29. Whereas ART services are offered country-wide in both public and private facilities and regional implementing partners are assigned to cover specific regions under the health systems strengthening programme, most of the services are largely supported by bi-lateral development partners. For example, the United States Government offers support through the Presidential Emergency Fund for AIDS Relief (PEPFAR), with the Global Fund providing substantial funding (and to a smaller extent there is domestic financing by the Government.)<sup>37</sup>

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<sup>33</sup> Uganda AIDS Commission *The HIV and AIDS Country Status Report 2014* p. viii

<sup>34</sup> Ibid p.11

<sup>35</sup> According to the Key Informant Interviews conducted in the PRDP region, the HIV/AIDS prevalence is on the rise.(UNDP Uganda Human Development Report p.52)

<sup>36</sup> Daily Monitor January 2016

<sup>37</sup> Uganda Aids Commission p.26

## Recommendations

30. The Government should work with the AIDS Development Partners Group, where WHO is a member, to accelerate comprehensive social and behavioural change communication, and improved programming and service delivery.

31. The Government should put in place a comprehensive sexuality education policy and strategy targeting schools and communities to enable adolescents and young people to make informed decisions about their sexuality and health.

32. The Government should strengthen the supply chain management capacity of the National Medical Stores to avoid drug stock-outs and to ensure timely supply and distribution of ARV drugs and HIV test-kits to all hospitals and health centers.

## D. ELIMINATION OF HARMFUL TRADITIONAL PRACTICES

### Universal Periodic Review Recommendations: Progress and Gaps in Implementation

33. One of the recommendations on the elimination of harmful traditional practices was for the Government to ensure the effective implementation of the Prohibition of Female Genital Mutilation Act and the prosecution and punishment of the perpetrators. The Government accepted the recommendation.<sup>38</sup> Whereas the Prohibition of Female Genital Mutilation Bill was enacted in 2010 a lot still remains to be done in terms of implementation and enforcement.

34. Public education, sensitisation and awareness raising interventions on the law targeting duty bearers, with the objective of catalysing implementation, have mainly been undertaken by civil society organisations (CSOs) and women parliamentarians with support from development partners. This is because the Government did not and has not appropriated funds for the implementation of the law. Another challenge is the absence of regulations to inform and guide implementation, inadequate funding for the Justice, Law and Order Sector (JLOS) to deliver on its mandate, understaffing in the Judiciary resulting in case back-log, the limited capacity of Uganda Police Force to deal with female genital mutilation cases, and more importantly the inaccessibility of printed copies of the law at sub-national level to inform and guide implementation by duty bearers in JLOS.<sup>39</sup>

### Background

35. Article 33 (6) in the Constitution prohibits laws, cultures, customs or traditions which are against the dignity, welfare or interest of women or which undermine their status.<sup>40</sup> The National Action Plan (NAP) on UN Security Council resolution 1325, 1820 and the Goma Declaration identifies female genital mutilation (FGM) as a form of sexual and gender-based violence that needs to be eliminated in Uganda, and the Prohibition of Female Genital Mutilation Act 2010 was specifically identified for implementation by Government, and with a specific monitoring indicator - *Indicator 7: Number and quality of gender responsive laws*

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<sup>38</sup> UPRWG Report: Paragraph 111.46 p.17

<sup>39</sup> Uganda Women Parliamentarians Association (UWOPA) Mid-Term Review Report 2014, (UWOPA) established that majority of duty bearers responsible for implementing the laws did not have access to the Domestic Violence Act and the Female Genital Mutilation Act and were ignorant of the provisions in these laws and their roles and responsibilities.

<sup>40</sup> The Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa of 2003, calls upon State parties to prohibit and condemn all forms of harmful practices against women.

*and policies.*<sup>41</sup> In September 2011, the NAP was revised to refocus the indicators, and align it with the National Development Plan (2010/2011-2014/2015), with assigned roles for different stakeholders, making it a multi-sectoral national action plan to address violence against women.<sup>42</sup>

36. The Prohibition of Female Genital Mutilation Act criminalizes discrimination against females that have not undergone FGM. Persons who carry out FGM on self or on others, procure, aid, induce, threaten or fail to report the practice are guilty of committing FGM and are liable to imprisonment, a fine or both.

### **Problem Identification**

37. Even though duty bearers were informed about the illegality of FGM when it was outlawed, FGM has persisted in some areas in north-eastern Uganda. In Kapchorwa District the practice is still done in a clandestine manner whereby communities still send the girls across the border into Kenya to avoid the local jurisdiction. There are still parents and girls who want the practice to continue.<sup>43</sup> Since the enactment of the law, there has only been one FGM case where perpetrators were arraigned, successfully tried and sentenced in a court of law. In 2014, seven FGM perpetrators were sentenced to four years imprisonment and incarcerated. The police believe that this incident increased awareness and instilled fear within the region, even though the President later pardoned the perpetrators.<sup>44</sup>

38. Without having regulations in place for the implementation of the Act, challenges with implementation and enforcement of the Act still remain. Real social transformation at the individual and community level, in terms of prevention of the practice, and improvement in the quality of life of the girls and later as adults, as a result of the enforcement of the FGM Act is not taking place. Lack of implementation and enforcement is also exacerbated by entrenched cultural norms, practices and negative attitudes perpetuated by patriarchy that deny girls the right to be free from all forms of violence and discrimination. In addition, inadequate or no funding for the districts where this practice still remains, continues to be a challenge.

### **Recommendations**

39. The Government should appropriate more resources for government led anti-FGM campaigns to increase community education and awareness.

40. The Government should direct the responsible government ministry to develop regulations to inform effective implementation of the Prohibition of Female Genital Mutilation Act (2010) so that young girls stop being subjected to this form of violence in areas where FGM is still being practised.<sup>45</sup>

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<sup>41</sup> Centre for Women in Governance (CEWIGO Report on the Implementation of the National Action Plan on UNSCR 1325, 1820 and the Goma Declaration, 2015CEWIGO Report 2015

<sup>42</sup> *Ibid*

<sup>43</sup> Uganda Women Parliamentarians Association Mid-Term Review Report 2015

<sup>44</sup> *Ibid*

<sup>45</sup> The Act under Part V Miscellaneous Provisions Section 17 clearly states, "The Minister may by statutory instrument make regulations for the implementation of this Act."

41. The Government should provide the necessary resources, particularly funding to the Justice, Law and Order Sector for the effective implementation and enforcement of the Prohibition of Female Genital Mutilation Act.