CENTER FOR REPRODUCTIVE RIGHTS

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Re: Supplementary Information on Uganda, scheduled for review by the Committee of Economic, Social and Cultural Rights during its 54th Pre-sessional Working Group

Distinguished Committee Members,

This letter is intended to supplement the initial periodic report submitted by the government of Uganda, which is scheduled to be reviewed during the 54th pre-session of the Committee on Economic, Social and Cultural Rights (the Committee). The Center for Reproductive Rights (the Center) a global legal advocacy organization with headquarters in New York and, and regional offices in Nairobi, Bogotá, Kathmandu, Geneva, and Washington, D.C., hopes to further the work of the CESCR Committee by providing independent information concerning the rights protected under the International Covenant on Economic, Social and Cultural Rights (CESCR),[1] and other international and regional human rights instruments which Uganda have ratified.[2]

This letters provides information on the following issues of great concern, which we hope the Committee will take into consideration during its review of Uganda: lack of access to comprehensive family planning services and information, lack of access to safe abortion services and post-abortion care, the high rates of preventable maternal mortality and morbidity; discrimination against people living with HIV and AIDS; and discrimination against women and girls, including violence, and forced pregnancy testing and expulsion of pregnant school girls. The information in this letter regarding unsafe abortion and lack of access to family planning information and services is drawn from the Center's fact-finding report, *The Stakes Are High: The Tragic Impact of Unsafe Abortion and Inadequate Access to Contraception in Uganda* (*The Stakes Are High*), [3] which has been submitted with this letter.

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I. The Right to Equality and Non-Discrimination

It has long been recognized that the obligation to ensure the rights to non-discrimination and substantive equality for all people underlies all human rights. Accordingly, states are required to address both de jure and de facto discrimination in private and public spheres.[4] They are further required to not only remove barriers but also take positive measures "to achieve the effective and equal empowerment of women."[5] To this end, they should 'adopt whatever legislation is necessary to give full effect to the principle of equality between men and women,"[6] develop policies that promote gender equality,[7] take efforts to eliminate gender stereotypes about women in the family and society,[8] and address practices that disproportionally impact women.[9] As the Committee noted, it is not sufficient for states to just guarantee women formal equality, as it does not adequately account for, and may even perpetuate, existing economic, social and cultural inequalities between men and women.[10] Instead, states must ensure women substantive equality,[11] which seeks to remedy entrenched discrimination by addressing inequalities that women face. In fulfilling women's right to substantive equality, states must ensure that laws, policies and practices alleviate the inherent disadvantages that particular groups face,[12] and ensure men and women equal enjoyment of economic, social and cultural rights.[13]

Similarly, it has been affirmed that to fulfill women's human rights, states must use all appropriate means to promote substantive equality. To this end, the Committee recognizes that states may need to adopt temporary special measures "in order to bring disadvantaged or marginalized persons or groups of persons to the same substantive level as others,"[14] which may include "tak[ing] measures in favour of women in order to attenuate or suppress conditions that perpetuate discrimination."[15]

One major element of women's right to equality and nondiscrimination is their ability to exercise reproductive autonomy—that is, to make decisions regarding whether and when to have a child without undue influence or coercion. For women to enjoy reproductive autonomy, their options must not be limited by lack of opportunities or results.[16] As such, it is crucial that women have access to reproductive health services, and that those services can be accessed with their consent alone.[17] In addition, reproductive health services must "be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice."[18]

II. The Right to Reproductive Health Care

Women and girls' right to access to comprehensive reproductive health services receive broad protection under all the major international and regional human rights instruments including the CESCR, which recognizes "the right of everyone to the enjoyment of the highest standard of physical and mental health."[19] The Committee, in General Comment 14, has clarified that the right to health protected under the Convention includes "the right to control one's health and body, including sexual and reproductive freedom."[20] General Comment 14 also specifically states that "[t]he realization of women's right to health requires the removal of all barriers

interfering with access to health services, education and information, including in the area of sexual and reproductive health."[21] In order to comply with this obligation, therefore, states are required to take "measures to improve child and maternal health, sexual and reproductive health services, including access to family planning … emergency obstetrics services and access to information, as well as to resources necessary to act of that information."[22] In the absence of these services, women and girls may experience unwanted pregnancies, and unsafe pregnancies and deliveries, possibly exposing them to life-threatening

Yet, women and girls in Uganda often lack access to essential reproductive healthcare services, which is apparent in the high rate of maternal mortality and morbidity, unplanned and unwanted pregnancies, and the number of women who suffer complications, often life-threatening, as a result of unsafe abortions.

A. Lack of Access to Comprehensive Family Planning Information and Services

Access to family planning services and information is critical to protecting women's and girls' rights to life and health. The Committee has consistently recognized that lack of access to family planning information and services violates the right to health[23] and that low contraceptive prevalence contributes to unsafe abortion and maternal death.[24] The CEDAW Committee—the Committee tasked with monitoring states' compliance with the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)—has called on Uganda to "take all necessary measures to improve women's access to health care and health-related services, including the promoting education on sexual and reproductive health.[25]

Family planning information and services in Uganda have shown some improvement throughout the years. The latest Demographic Health Survey (UDHS) shows that the unmet need for contraceptives decreased from 41% in 2006[26] to 34% in 2011,[27] while the use of modern contraception increased from 15% in 2007[28] to 26% in 2011.[29] The government, in its initial report to the Committee, attributes this progress to the improved management of family planning commodities.[30] However, although in the 2014/2015 budget, the government has allocated USD 6.9 million to reproductive health commodities, there is still a USD 2.4 million funding gap.[31] Also, despite the improvement in the level of usage of contraceptives, about three quarters of Ugandan women still do not use modern contraception[32] and 42% of pregnancies in Uganda are unintended.[33] There are also disparities in usage of contraceptives depending on women's level of education, their geographical location and wealth quintiles. For instance, 44% of currently married women with secondary or more education are using a contraceptive method compared to only 18% of the married women who have no education.[34]

The low contraceptive use can be attributed to the numerous barriers women and girls encounter in trying to access family planning services including user fees, unavailability of preferred contraceptive method,[35] improper counseling services,[36] lack of information about contraceptives, and absence of necessary supplies to insert certain methods.[37] A 2006 survey

revealed that fear of side effects, inconvenience of using modern contraceptives, partners opposing contraceptive use, and belief that contraceptives are prohibited by religion inhibit women from using modern contraceptives.[38]

The Center's 2013 fact-finding report, *The Stakes Are High*, made similar findings and documented the impact on women's lives. In one instance, Nansubuga, a woman who lives in Kampala, talks about discontinuing the use of contraceptives because she believed that one could not get pregnant after having used family planning for a long time.[39] However, she conceived immediately after she stopped using the pill temporarily and ultimately underwent a clandestine abortion.[40] Joyce, another woman interviewed for the study, told us how her husband beat her because of his misconception about contraceptive use saying: "He didn't want me to take the pills because [he said] they destroy a woman's reproductive health. [He said they] also destroy their sexual urge. That's what he told me and he gave me a thorough beating. He beat me very badly; all of my body was swollen."[41]

Other women reported hesitance to obtain contraceptives because using or even discussing contraceptives with their spouses or male partners could imply infidelity.[42] As one interviewee noted, "women exercising control over their own reproductive choices are often suspected of being unfaithful to their husbands or engaging in other illicit activities."[43] In addition, lack of information about the different contraceptive methods and where to access them is a significant barrier to access. One research found that 13% of women surveyed indicated that they did not know where they could obtain contraceptives or they could not access a health center that offers contraceptives.[44] In the Center's publication, *The Stakes Are High,* Edith, a sex worker, explains having to go through an unplanned and unwanted pregnancy and multiple unsafe abortions because she didn't have knowledge and information about contraceptive methods and services.[45] She noted that her life changed once she had access to family planning services.[46]

Lack of equality and discrimination against women—demonstrated through their lack of autonomy to decide whether and when to have children, and providers' negative attitude towards women and girls who are not married but seek contraceptive services—is also a major barrier to use. The power imbalance between men and women often makes it difficult for women to negotiate contraceptive use, especially male controlled methods such as condoms, with their partners.[47] As one interviewee, a volunteer in one local clinic in Kampala told us:

> "It's difficult to tell a man to wear a condom, especially if that man is your husband. When he refuses, there's no way [you can] force him to wear it. How can a man buy for you food when you have denied to give him sex? It is very difficult to deny your husband sex, because he is entitled, and if you refuse, he has a right to ask you to leave the home."[48]

Women also face the personal bias of healthcare providers resulting in discrimination in healthcare facilities as third-party or spousal consent is often imposed as a condition to access family planning

services, even though this is not required under Uganda's laws and policies.[49] In addition to women who are married, this practice is particularly discriminatory towards unmarried women and adolescents as they are not able to produce such consent.

The right to enjoy the benefits of scientific progress, which is guaranteed in the Covenant,[50] should include family planning services, specifically all kinds of modern contraceptives. However, use and awareness of the Emergency Contraceptive (EC)—a critical component of care for survivors of sexual violence, and a method that could reduce the number of unintended pregnancy and unsafe abortions[51]—remains low.[52] The 2007 Uganda Service Provision Assessment Survey shows that the number of women who have ever used EC in Uganda is close to zero, while just 18% of health facilities that offer any family planning services reported supplying EC.[53] The 2011 DHS has also reported that only 31% of women know about EC.[54]

Healthcare workers also lack accurate information about EC and display bias which reduces its use and acceptance.[55] There is insufficient training on the proper use of, and counseling on, EC.[56] Common misperceptions about EC include the notion that it will inhibit future fertility, cause extreme side effects,[57] and encourage sexual promiscuity.[58] However, these perceptions are unfounded as the World Health Organization (WHO) has noted that the side-effect of EC are uncommon and generally mild, and do not affect fertility.[59]

B. Prevalence of Unsafe Abortion and Lack of Post-Abortion Care

Unsafe abortion is one of the most easily preventable causes of maternal mortality and morbidity. When it does not result in death, complications arising from unsafe abortion can, and often do, expose women to the risk of long-term disabilities.[60] The Committee's General Comment 14 emphasizes that states are obligated to reduce women's health risks and lower maternal mortality rates.[61] The Uganda government has failed in this obligation by failing to address maternal mortality resulting from unsafe abortion. In its report to the Committee, the government noted that it has ratified the Maputo Protocol but has entered reservation on the Art. 14 (2) (c) which requires states to permit abortion in cases of sexual assault, rape, incest and where the mental and physical health of the mother, or the life of the mother or the fetus is in danger.[62] The government further noted that, "[a]lthough abortion is illegal in Uganda, tremendous improvements in the reproductive health of women have been achieved."[63] Yet, the government failed to detail what these improvements are.

Under the Constitution and the Penal Code, abortion is allowed only when the woman's life is in danger.[64] Pre-independence jurisprudence, which still applies in Uganda, clarifies that the life exception in the Penal Code also includes physical and mental health.[65] Further, the *Uganda National Guidelines and Services Standards for Sexual and Reproductive Health and Rights* (Reproductive Health Guidelines) provide expanded grounds for permitting legal abortion, such as sexual violence and incest, and outline comprehensive abortion and post-abortion care standards.[66] However, the limited interpretations of the legal framework by the courts and other

government bodies, and the extremely restricted access to relevant information, have resulted in lack of comprehensive information about the law among women, healthcare providers, law enforcement, the judiciary, and regulators, among others.[67]

As documented in *The Stakes Are High*, most doctors and other trained providers mistakenly believe that abortion is completely prohibited and are reluctant to provide the comprehensive services outlined in the Reproductive Health Guidelines, for fear of being subjected to criminal liability under the Penal Code.[68] Dr. Andrew, an interviewee who has practiced gynecology for 20 years, noted he used to tell the women who came to him seeking abortion "get out from my sight" because he was told, during his medical training, that abortion is a criminal offence. [69] Because of this belief, he said, "[w]e used to refuse a lot of them, and then three to four days later they are calling me for an emergency ward, and you have to provide emergency service. So you lose [patients' lives] and then you wonder [if] that is better than not helping them earlier."[70]

The widespread misconception that abortion is completely illegal does not diminish the number of abortions sought in Uganda; rather, as evidence shows, it causes more women to seek unsafe clandestine abortions.[71] Most recent estimates state that approximately 362,000 induced abortions are performed in Uganda every year, a figure that has increased over the past several years.[72] About 1,200 women die each year from unsafe abortions while approximately 85,000 receive treatment for complications, and approximately 65,000 experience complications but receive no treatment.[73] The average woman in Uganda has a 50% chance of being treated for an abortion complication over the course of her lifetime.[74] Although there is no exact data on the number of deaths resulting from unsafe abortions, the Ugandan Ministry of Health estimates the figure is about 26%,[75] indicating that clandestine abortions are a major cause of Uganda's high maternal mortality rate.[76] The CEDAW Committee has articulated its concern over this issue,[77] especially in respect to adolescent girls,[78] and recommended that the Uganda implement national reproductive health programs to prevent unsafe abortions.[79]

Also, research shows that low-income women and those living in rural areas have limited access to safe abortion services. [80] Only 10% of poor rural women can access safe abortion performed by doctors as opposed to 50% of non-poor urban women.[81] Wealth affects access too: among unintended pregnancies in the wealthiest quintile of women, 23% end in abortion, whereas for women in the poorest quintile of the population, only 14% end in abortion.[82] This difference is mainly due to unequal access to healthcare providers: women with higher income tend to —and can afford to—seek abortion care from skilled healthcare providers whereas low-income women, especially those living in rural areas, have less access to doctors and are more likely to rely on unsafe abortion services provided by unskilled providers or to induce abortion themselves.[83]

Low-income women in Uganda are two times as likely to induce their own abortions and only one-third as likely to have their abortions performed by doctors, as compared to women.[84] Further, the cost of obtaining an abortion from a physician is significantly higher than that of a traditional provider.[85] Tewi, a 31-year-old woman who was living with HIV-AIDS, had to pay

200,000 Uganda Shillings (about USD 77) in order to procure a safe abortion from a doctor who performed the service clandestinely,[86] even though the Reproductive Health Guidelines provides that women living with HIV-AIDS are entitled to legal abortion services.[87] She noted that she was only able to afford to pay such a high amount for a safe abortion because she had some personal wealth. Still, she said "It was damn expensive, but I had to do it."[88] These costs are unaffordable for many women in Uganda—about one quarter of the population lives below the poverty line of USD 1.25 per day.[89]

Post-Abortion Care (PAC)

According to Uganda's Reproductive Health Guidelines, PAC is a component of maternal and newborn health services in Uganda, and should be provided to women who have had an abortion "of any cause."[90] It also requires PAC to be provided on a 24-hour basis,[91] by doctors, midwives and other trained professionals, in a place where minimum hygienic conditions are met.[92] However, evidence shows that most healthcare facilities in Uganda are poorly equipped to manage PAC. Supplies crucial to the provision of PAC are only available in very few of the health facilities offering delivery services.[93] Health service providers receive less training in PAC than almost any other area of skills training, with just 8% of providers receiving training in the year preceding the 2007 Uganda Service Provision Assessment Survey, the latest survey on this data.[94] Only 51% of poor rural women who suffer abortion complication seek medical assistance.[95] In addition, due to the misconception about the legality of abortion discussed in the previous section, doctors may also refuse to perform PAC for fear of being reported to the police.[96]

Further, a survey of Ugandan women also revealed that women do not seek medical treatment for abortions or related complications because of fear of negative reactions and mistreatment from healthcare providers.[97] The Center's report, *The Stakes Are High*, further confirmed this--Maureen, an interviewee, spoke about her cousin who suffered complications and died due to an unsafe abortion performed by a health worker who pierced her intestine because he was "in a hurry to get out and go."[98] She developed diarrhea but tried to control it through self-medication as she feared mistreatment if she goes to a medical facility. Maureen's cousin suffered for a week before her condition became unbearable and she was admitted to a health facility. For fear of stigmatization, she initially told the health workers she had malaria. After her condition worsened, she told the health workers about the abortion and was then referred to a hospital but ultimately died.[99]

This fear of stigma, however, is not unfounded as evidence shows that the negative attitude of healthcare providers, often fuelled by their personal bias about abortion, also impacts their provision of quality care to women perceived to be seeking PAC services. As was also documented in *The Stakes Are High*, Elizabeth, a medical doctor at Mulago Hospital which provides PAC, talked about her sister Martha, who faced stigma when she went to the hospital complaining of severe pains. Upon telling the nurses that she had once had an abortion, they

assumed she had had an illegal abortion and practically abandoned her in the waiting area. Martha was left in the waiting area for a long time until Elizabeth called a colleague who managed to get her into surgery. Martha was stigmatized throughout her time at the hospital including in the recovery ward, although surgery revealed that Martha's pain was caused by a burst dermoid cyst in her ovary. Martha refused to go back to the hospital even when she later experienced some complications.[100] This account illustrates the unwelcoming environment prevalent in qualified health service facilities and how the hostile environment often leads women to seek out back-door clinics or other care for PAC and ultimately only seeking care in a hospital when it is almost too late.

C. High Incidences of Preventable Maternal Mortality and Morbidity

The WHO defines maternal death as any death that occurs during pregnancy, childbirth, or within 42 days after birth or termination of a pregnancy.[101] This committee, as well as other bodies that monitor compliance with various international human right treaties—such as the International Covenant on Civil and Political Rights (ICCPR) and the CEDAW—have all framed the issue of maternal mortality as a violation of women's right to health and right to life.[102] The CEDAW Committee, concerned over the "very high" maternal mortality in Uganda[103] has recommended that the government "strengthen its efforts to reduce the incidence of maternal and infant mortality."[104] Uganda, according to the government's report to the Committee, is implementing these recommendation by rolling out core interventions identified in the Roadmap to reduce Maternal and Neonatal Mortality and Morbidity While these efforts are commendable, and as per the report, 63% of districts are implementing strategies outlined in the Roadmap as of FY 2009/2010,[105] these interventions do not seem to be yielding the intended results.

According to the government's 2013 Millennium Development Goal (MDG) Report, the maternal mortality ratio (MMR) has not shown statistically significant change:[106] the ratio was 435 in 2006 [107] and 438 maternal deaths per 100,000 live births in 2011,[108] with maternal deaths accounting for 18% of all deaths of women aged 15-49.[109] In addition, for every maternal death, 6 women suffer severe morbidities such as anemia, infertility, pelvic pain, incontinence, and obstetric fistula. [110] In the MDG report, the government also acknowledges that it is unlikely that the goal of reducing the MMR by three quarters by 2015 will be met.[111]

In order to reduce the high mortality ratio, it's crucial that women and girls in Uganda have access to comprehensive maternal health services including ante-natal, delivery and post-natal care. Although the attendance of ante-natal care (ANC) is at 95%[112] the number of women who attend the WHO recommended four visits[113] has not shown any improvement in the past decade: the 2006 UDHS reported that 47% of women attended the minimum visits while the 2011 UDHS reported only 48%.[114] Furthermore, only 22% of the facilities that provide ANC services in Uganda are equipped with the essential supplies necessary for basic ANC services,[115] and only 6% of facilities carry the minimum medications required to manage common but life-threatening pregnancy complications including anemia, pre-eclampsia and eclampsia,.[116]

Access to quality delivery care is also a serious problem in Uganda. According to the 2011 UDHS, 43% of women in Uganda give birth outside of a healthcare facility,[117] among which 18% give birth with a traditional birth attendant, 15% are attended by a relative, and 7% give birth unattended.[118] While the number of births that have been attended by a skilled provider has increased from 42% in 2006[119] to 58% in 2011,[120] still a significant percentage of births are not attended by a skilled provider.

Further, even if women seek delivery services in healthcare facilities, most of the facilities are not well equipped to provide comprehensive delivery services. The most recent data available from Uganda reports that only about half of healthcare facilities offer basic delivery services,[121] only 5% offer cesarean section delivery,[122] and less than half of healthcare facilities are equipped with transportation for maternity emergencies.[123] Half of healthcare facilities are able to offer 24-hour delivery care by a trained medical provider, but only 5% have protocols in place for such services.[124] Further, just 5% of births occur in facilities that are equipped for emergency obstetric care,[125] and only a small fraction (less than 3%) of the facilities that are expected to be able to offer basic emergency obstetric care could in fact offer it.[126] While post-natal care is a critical component of preventing post-delivery maternal mortality, [127] 64% of women in Uganda receive the service at all.[128] Of the women that do receive PPC, only 21% receive care within the first 4 hours after delivery while 33% receive care within the first two days.[129]

In Uganda's 2012 Universal Periodic Review, the Human Rights Council recommended that the government increase access to sexual and reproductive health services by raising the health budget to 15%.[130] However, although the government has accepted this recommendation, and has expressed its commitment to improving maternal health with the goal of reducing mortality and morbidity,[131] and described the current MMR as "unacceptably high,"[132] reproductive health services are still severely underfunded. The budget allocation for the health sector for 2012-2013 only accounted for 7.8% of the total government's budget, [133] and the budget for 2013-2014 was only 8.6%.[134] This falls short of the government's commitment to allocate at least 15% of the annual national budget to the health sector as stipulated in the Abuja Declaration.[135] The failure to provide sufficient funding to the health sector, which would also have an affect maternal health services, demonstrates a corresponding failure to prioritize maternal health issues, which results in insufficient antenatal, delivery, and post-partum care.

D. Adolescents' Access to Reproductive Healthcare Information, including Sexuality Education and Services

Adolescents often lack access to reproductive healthcare information and services making them vulnerable to risks to their life and health due to early pregnancies and sexually transmitted infections.[136] International human rights treaty monitoring bodies recognize that sexuality education contributes to the prevention of HIV and AIDS,[137] adolescent and unwanted pregnancies, [138] unsafe abortion,[139] and maternal mortality.[140] As such, treaty monitoring bodies

have urged states to implement sexuality education programs in all schools[141] as well as in other settings in order to reach adolescents who are not enrolled in schools.[142]

To comply with human rights standards, sexual and reproductive health information and education should be comprehensive, unbiased, and scientifically accurate.[143] However, research has revealed that only half of sexually active adolescents in Uganda receive sexuality education in schools.[144] 39% of girls and 38% boys attend schools that do not provide any type of sexuality education.[145] Even when sexuality education is provided, it is not comprehensive: as one women's right advocate explains, "Sex is taught with a lot of fear, taught with sugar coating and hiding."[146]

This lack of information and services leads to the high rates teenage pregnancy, making Uganda one of the countries in the world with the highest teen pregnancy rates. [147] The 2011 UDHS found that 20.8% of young women in Uganda began childbearing by age 17 and 48.7% had given birth to one or more children by age 19.[148] Adolescent pregnancy is of particular concern due to the association between young maternal age and the greater risk of maternal mortality and morbidity, and pregnancy related complications.[149]

III. Discrimination against Women and Girls

The right to equality and non-discrimination is a core principle that underlies international and regional human rights standards. The Committee has imposed upon the states an obligation to eliminate discrimination, specifically as expressed through "prejudices, customary and all other practices that perpetuate the notion of inferiority or superiority of either of the sexes, and stereotyped roles for men and women."[150] Similarly the African Charter and the Maputo Protocol require states to eliminate every discrimination against women[151] "though appropriate legislative, institutional and other measures,[152] including by undertaking measures to address the "social and cultural patterns" that perpetuate discrimination against women and girls.[153] Particularly, the CEDAW Committee has expressed concern over customs and practices in Uganda that perpetuate discrimination against women,[154] and called upon the government to address direct and indirect discrimination against women.[155] The Human Rights Council has recommended that Uganda adopt a comprehensive strategy to eliminate traditional practices and stereotypes that discriminate against women and that it revise and amend current legislation to ensure that it does not discriminate against women.[156]

A. Discrimination and Stigma against Women with HIV and AIDS

Discrimination and stigma against people with HIV is a human rights violation.[157] The CESCR has noted that, "[s]tates have a special obligation . . . to prevent any discrimination on internationally prohibited grounds in the provision of health care and health services, especially with respect to the core obligations of the right to health."[158] Yet, in July 2014, the Ugandan President signed into law the "HIV and AIDS Prevention and Control Bill, 2010" (the HIV

Bill),[159] which contains several provisions that have the potential of negatively affecting women living with HIV/AIDS. [160]

The HIV Bill's provisions that require mandatory HIV testing without informed consent violate the right to health, privacy and nondiscrimination enumerated in the Covenant, CEDAW, ICCPR and the Maputo Protocol.[161] Compulsory testing of pregnant women may deter women from seeking healthcare, directly contravening the Ugandan government's ability to prevent the spread of HIV and make improvements in maternal health care. The International Guidelines on HIV/AIDS and Human Rights recognize that the compulsory testing of pregnant women is a coercive measure that ineffectively combats the spread of HIV and restricts the human rights of the individual[162] which can result in "reduced participation and increased alienation of those at risk of infection."[163] Even when pregnant women learn their HIV status, appropriate treatment is often not available. Preventing Mother-to-Child Transmission (PMTCT) treatment is only integrated into ANC and delivery services at 43% of health facilities in Uganda.[164] Rather than focusing on compulsory testing of pregnant women, efforts would be better directed at strengthening the delivery of maternal health and PMTCT services and increasing women's confidence in maternal health services.

The HIV Bill contains two more provisions of particular relevance and risk to women. The first allows healthcare providers to release results of an HIV and AIDS test to a patient's sexual partners without the patients consent, potentially exposing the patient to stigma, discrimination, and violence.[165] If women believe their HIV status may be disclosed, they may be discouraged from seeking the necessary healthcare services, contradicting government HIV and reproductive health initiatives.[166] The second provision criminalizes intentional transmission of HIV and includes harsh penalties that would expose women living with HIV to more risks of human rights violations.[167] HIV testing is routinely provided as a part of prenatal care, making women more likely to learn about their HIV status and similarly more likely to be accused of intentional HIV transmission. This could lead women to forego HIV treatment and care, making criminalization ineffective at containing the spread of HIV.

B. Violence against Women and Girls

In 2010, the CEDAW Committee, while commending the government for passing the Domestic Violence Bill, expressed concern over the high prevalence of violence against women and girls, and called upon the state to give the issue "priority attention".[168] However, in the report submitted to the Committee, even though the government stated that it has passed the Domestic Violence Act[169] and a National Action Plan for the implementation of the CEDAW which includes freedom from violence as one area,[170] it did not provide information on their implementation as well as other measures undertaken to curb the root causes of violence.

Due to the government's failure to effectively address the situation, violence against women and girls remains alarmingly high. According to the 2011 UDHS, 56% of women age 15-49 have

experienced physical violence at least once since the age of 15 and 28% have experienced sexual violence.[171] Six in ten ever married women in the same age group reported having experienced emotional, physical, or sexual violence from their spouse.[172] This level of violence has not shown any improvement from 2006 when 60% of women reported having experienced physical violence at least once since the age of 15.[173] In the same year, 66% of Ugandan women also reported having suffered sexual violence at the hands of their current or former husband or partner.[174] Further, according to the most recent reports from the Uganda Police, reports of domestic violence increased by 18.4%: from 2,793 cases reported in 2012 to 3,426 cases in 2013.[175] Also, 360 deaths resulted from domestic violence—among which 159 were females—an increase from 277 deaths reported in 2012.[176] Even when sexual violence is reported, women frequently face indifference to these crimes and impunity for their assailants. In 2013, 1,365 rape cases were reported, out of which only 365 were taken to court and a mere 11 resulted in convictions.[177] Further, out of the 19,508 defilement cases reported, only 9,598 were investigated and 359 convicted.[178]

Violence against children is also a grave problem in Uganda. A 2005 study found that 98% of children reported having experienced physical or emotional violence with over 75% reporting having experienced some kind of sexual violence or harassment.[179] Among these children, 24% reported that the sexual violence they suffered occurred mainly at school while 34% reported that the abuse happened at home and at school.[180] Two years later, another study found that 23% of girls reported that their first sexual encounter was forced.[181] In addition, a 2010 report shows that 8% of girls age 16-17 have had sex with their teachers.[182] Two primary reasons are the fear amongst school girls of the consequences of refusing a teacher's sexual advances as well as the practice of teachers luring girls into having sex by promising them good grades or gifts.[183]

Many factors contribute to the continuation of the violence against Uganda women and girls. Cultural and societal views, which place women at an inferior position that men, and normalize violence against them, are one such factor. Joyce, as reported in the *Stake are High*, experienced domestic violence as a result of her husband's misconception about contraception. He beat her ruthlessly after he found out that she has been using contraception for six years.[184] He abandoned her and their five children, when she reported him to the police.[185]

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

a. What measures are being taken to address the lack of information about family planning, including myths and misconceptions about the side-effects of contraception? What steps is the government undertaking to ensure sufficient supplies of family planning and contraceptive methods? What steps is the government taking to improve awareness about, and the availability of, emergency contraception?

b. Given the widespread misperception that abortion is completely illegal, what concrete measures are being taken to promote national awareness of the legal grounds for abortion? What other measures are being taken to review the existing abortion laws, health policies, and guidelines to ensure they are consistent with international and regional human rights standards?

c. How will the government reduce the high levels of unsafe abortions in Uganda? What steps has the government taken to ensure equal opportunities for rural and low-income women and adolescents to receive respectful and comprehensive post-abortion care?

d. What concrete steps is the government taking to meet its commitment to reducing the maternal mortality rate in Uganda to 132 deaths per 100,000 live births by 2015? How does the government plan to expand availability of and access to emergency obstetric care and decrease the number of complications from deliveries not performed by skilled providers?

e. Has the government implemented its plans to introduce sexuality education in schools? What measures has it taken to ensure that sexuality education is comprehensive and scientifically accurate? What efforts have been made to reduce the high rates of adolescent pregnancy including by providing adequate reproductive and sexual health services and information?

f. Have structures been set up to tackle the rights violations experienced by people living with HIV/AIDS? In particular, will the government amend provisions in the HIV and AIDS Prevention and Control Bill which require compulsory HIV testing of pregnant women and disclosure of results without consent, among other violations?

g. What steps will the government take to gather updated information about sexual violence? How does the government plan to combat impunity for those who commit acts of sexual violence?

We hope that the Committee will consider making the following recommendations to the government of Uganda

a. The government should take concrete steps to ensure an adequate and consistent supply of contraceptives, including emergency contraceptives, initiate civic education campaigns to ensure sufficient and non-discriminatory access to family planning information and services and develop comprehensive guidelines obligating healthcare facilities to provide accurate and comprehensive family planning information, without discrimination.

b. The government should remove its reservation on Article 14 of the Maputo Protocol and review its abortion law to ensure it is consistent with international and regional human rights standards. It should implement nationwide awareness raising strategies to dispel the misperceptions about when abortion is legal, and increase the number of health facilities that can provide legal and safe abortion and comprehensive post-abortion care services, including in rural areas.

c. Uganda should increase the number of healthcare facilities equipped and staffed to handle basic and emergency obstetric care, especially in low-income and rural areas, and increase the number of skilled healthcare providers able to offer quality ante-natal, delivery, and post-natal care. The government should also facilitate reliable and affordable transportation to quality healthcare facilities for pregnant women in low-income and rural areas to reduce preventable maternal mortality.

d. The government should provide sexuality education to all adolescents, in and out of school, and incorporate sexual and reproductive health education as a part of the curriculum in schools to address the prevalence of unplanned pregnancy among adolescents. It should also adopt measures to ensure ease of access of contraception for adolescents without risk of stigma or violence.

e. The government should implement strategies to reduce stigmatization and discrimination of persons living with HIV and AIDS, especially in healthcare facilities. It should ensure that the laws and policies already in place prevent and prohibit discrimination against those living with HIV and AIDS. Further, it should amend the provisions in the HIV and AIDS Prevention and Control Bill that require compulsory HIV testing, disclosure of results without consent, and criminalization of HIV transmission which are counterproductive to providing effective healthcare and violate human rights.

f. The government should institute investigation procedures and strict punishments for those found to have abused children. These procedures should include an oversight mechanism to help regulate and eradicate sexual and other violence against children, including those committed in schools.

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[1] International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976) (*ratified by* Uganda Jan. 21, 1987) [hereinafter ICESCR].
[2] Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), *adopted* Dec. 18, 1979, G.A. Res. 34/180, 34 U.N. GOAR, Supp. No. 46, at 193, U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981) (*ratified by* Uganda Jul. 22, 1985) [hereinafter CEDAW]; International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into* force Mar. 23, 1976) (*ratified by* Uganda Jun. 21, 1995) [hereinafter ICCPR]; African Charter on Human and Peoples' Rights, *adopted* June 27, 1981, O.A.U. Doc. CAB/LEG/67/3, rev. 5, 21 I.L.M. 58 (1982) (*entered into force* Oct. 21, 1986) (*ratified by* Uganda May 10, 1986) [hereinafter African Charter]; Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2nd Ordinary Sess., Assembly of the Union, *adopted* July 11, 2003, CAB/LEG/66.6 (*entered into force* Nov. 25, 2005) (*ratified by* Uganda Jul 22, 2010) [hereinafter Maputo Protocol].
[3] The report was published by the Center, O'Neill Institute for National and Global Health Law and the International Women's Human Rights Clinic at Georgetown Law in 2013.
[4] Human Rights Committee, *Concluding Observation: Jordan*, para. 7, U.N. Doc. CCPR/C/JOR/CO/4 (2010).
[5] Human Rights Committee, *General Comment No. 28: Article 3 (The equality of rights between men and women)*, (68th Sess., 2000), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 3, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) (emphasis added).
[6] Human Rights Committee, *Concluding Observation: Dominican Republic*, para. 10, U.N. Doc. CCPR/C/DOM/CO/5 (2012).
[7] Human Rights Committee, *Concluding Observation: Guatemala*, para. 8, U.N. Doc. CCPR/C/GTM/CO/3 (2012).
[8] Human Rights Committee, *Concluding Observation: Cape Verde*, para. 8, U.N. Doc. CCPR/C/CPV/CO/1 (2012).
[9] Human Rights Committee, *Concluding Observation: Canada*, para. 20, U.N. Doc. CCPR/C/79/Add.105 (1999).
[10] Committee on Economic, Social and Cultural Rights (ESCR Committee), *General Comment No. 16: The equal right of men and women to the enjoyment of all economic, social and cultural rights (Art. 3)*, (34th Sess., 2005), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, paras. 7-8, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *General Comment No. 16*].
[11] *Id.* paras. 6-7.
[12] *Id.* para. 7.
[13] *Id.* para. 9.
[14] *Id.* para. 15.
[15] *Id.*
[16] Rebecca Cook, *Human Rights and Reproductive Self Determination*, 44 The American University Law Review 975, 1007 (1995).
[17] *Id.*
[18] CEDAW Committee, *General Recommendation No. 24: Article 12 of the Convention (women and health)*, (20th Sess., 1999), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, art. 24, para. 31(e), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW *General Recommendation No. 24*].
[19] ESCR Committee, *General Comment No. 14: The right to the highest attainable standard of* health (Art. 12), (22nd Sess., 2000), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 14, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *General Comment No. 14*).
[20] *Id.*
[21] *Id.*
[22] *Id.*
[23] CENTER FOR REPRODUCTIVE RIGHTS & UNIVERSITY OF TORONTO PROGRAMME OF REPRODUCTIVE AND SEXUAL HEALTH LAW, BRINGING RIGHTS TO BEAR: AN ANALYSIS OF THE WORLD OF U.N. TREATY MONITORING BODIES ON REPRODUCTIVE AND SEXUAL RIGHTS 117 (2002). This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See, e.g.*, ESCR Committee, *Concluding Observations: Armenia*, para. 15, U.N. Doc. E/C.12/1/Add.39 (1999); *Cameroon*, para. 25, U.N. Doc. E/C.12/1/Add.40 (1999); *Dominican Republic*, para. 15, U.N. Doc. E/C.12/1/Add.16 (1997); *Dominican Republic*, para. 22, U.N. Doc. E/C.12/Add.6 (1996); *Honduras*, para. 27, U.N. Doc. E/C.12/1/Add.57 (2001); *Paraguay*, para. 16, U.N. Doc. E/C.12/1/Add.1

(1996); *Poland*, para. 12, U.N. Doc. E/C.12/1/Add.26 (1998); *Saint Vincent and the Grenadines*, para. 12, U.N. Doc. E/C.12/1/Add.21 (1997).
[24] ESCR Committee, *Concluding observations: Dominican Republic*, paras. 28-29, U.N. Doc. E/C.12/DOM/CO/3 (2010); *see also* ESCR Committee, *Concluding observations: Philippines*, para. 31, U.N. Doc. E/C.12/PHL/CO/4 (2008); *Nicaragua*, paras. 26-27, U.N. Doc. E/C.12/NIC/CO/4 (2008); *Azerbaijan*, para. 30, U.N. Doc. E/C.12/1/Add.104 (2004); *Poland*, para. 12, U.N. Doc. E/C.12/1/Add.26 (1998).
[25] CEDAW Committee, *Concluding Observations: Uganda*, para. 36, U.N. Doc. CEDAW/C/UGA/CO/7 (2010).
[26] UGANDA BUREAU OF STATISTICS, UGANDA DEMOGRAPHIC AND HEALTH SURVEY 2006 tbl. 40.6 (2007), *available at* http://www.measuredhs.com/pubs/pdf/FR194/FR194.pdf [hereinafter 2006 UDHS].
[27] UGANDA BUREAU OF STATISTICS, UGANDA DEMOGRAPHIC AND HEALTH SURVEY 2011 77 &89 (2007), *available at* http://www.measuredhs.com/pubs/pdf/FR194/FR194.pdf [hereinafter 2011 UDHS].
[28] MINISTRY OF HEALTH, UGANDA SERVICE PROVISION ASSESSMENT SURVEY 2007 88 (2008) [hereinafter PROVISION ASSESSMENT].
[29] 2011 UDHS, *supra* note 27, at 79.
[30] Uganda, *Consideration of reports submitted by States parties under articles 16 and 17 of the International Covenant of Economic Social and Cultural Rig*hts, para 147, U.N. Doc. E/C.12/UGA/1 (2013) [Government Report].
[31] A. Kalangwa, *AWLN Uganda and RHU advocate for closing of the funding gap for FP and RH commodities in the FY 2014/2015 budget*, AFRICAN WOMEN LEADERS NETWORK FOR REPRODUCTIVE HEALTH & FAMILY PLANNING, 2014, http://www.africawln.org/awln-uganda-and-rhu-advocate-for-closing-of-the-funding-gap-for-fp-and-rh-commodities-in-the-fy20142015-budget/ (last visited Oct. 15, 2014).
[32] 2011 UDHS, *supra* note 27, at 79.
[33] SUSHEELA SINGH ET AL., UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA: CAUSES AND CONSEQUENCES 19-20 (2006), *available at* http://www.guttmacher.org/pubs/2006/11/27/UgandaUPIA.pdf [hereinafter UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA].
[34] Further, contraceptive-use rate for women is 46% in urban areas compared to 27% in rural areas; 48% of married women in Kampala compared to only 8% in Karamoja; and 46% of women in the highest wealth quintile compared to 15% in the lowest wealth quintile, 2011 UDHS, *supra* note 27, at 81.
[35] PROVISION ASSESSMENT, *supra* note 28, at 92.
[36] 2011 UDHS, *supra* note 27, at 93-96.
[37] PROVISION ASSESSMENT, *supra* note 28, at 97.
[38] UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA, *supra* note 33, at 22.
[39] CENTER FOR REPRODUCTIVE RIGHTS ET AL., THE STAKES ARE HIGH: THE TRAGIC IMPACT OF UNSAFE ABORTION AND INADEQUATE ACCESS TO CONTRACEPTION IN UGANDA 44 (2013) [hereinafter STAKES ARE HIGH].
[40] *Id.*
[41] *Id.* at 45.
[42] GUTTMACHER INSTITUTE, *Benefits of Meeting the Contraceptive Needs of Ugandan Women, In Brief*: No. 4 4 (2009), *available at* http://www.guttmacher.org/pubs/IB_Contraceptive-Needs-Uganda.pdf [hereinafter *Benefits of Meeting Needs*].
[43] STAKES ARE HIGH, *supra* note 39, at 54.
[44] UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA, *supra* note 33, at 22.
[45] *See* STAKES ARE HIGH, *supra* note 39, at 42-43.
[46] *See Id.* at 42-43.
[47] *See Id.* at 48.
[48] *Id.* at 48.
[49] *Id.* at 50.
[50] ICESCR, *supra* note 1, art. 15(b).
[51] CENTER FOR REPRODUCTIVE RIGHTS, BRIEFING PAPER: GOVERNMENTS WORLDWIDE PUT EMERGENCY CONTRACEPTION INTO WOMEN'S HANDS: A GLOBAL REVIEW OF LAWS AND POLICIES 1 (2004).
[52] Josaphat K. Byamugisha et al., *Emergency Contraception and Fertility Awareness among University Students in Kampala, Uganda 6* AFR. HLTH. SCIENCES NO. 4 56 (2006) [hereinafter Byamugisha].
[53] PROVISION ASSESSMENT, *supra* note 28, at 19, tbls. A-5.2.1, A.5.2.2.
[54] 2011 UDHS, *supra* note 27, at 78.
[55] *See*, Byamugisha, *supra* note 52, at 22-23.
[56] *Id.* at 56-57.
[57] *Id.* at 48.

[58] *See Id.*
[59] *See* WORLD HEALTH ORGANIZATION (WHO), FACT SHEET: EMERGENCY CONTRACEPTION, NO. 244 (2012), *available at* http://www.who.int/mediacentre/factsheets/fs244/en/.
[60] Friday Okonofua, *Abortion and Maternal Mortality in the Developing World*, 28(11) J Obstet Gynaecol Can 974, 975 (2006), *available at* http://www.sogc.org/jogc/abstracts/full/200611_WomensHealth_1.pdf.
[61] ESCR Committee, *General Comment No. 14*, *supra* note 19, para. 21.
[62] Government Report, *supra* note 30, para. 31.
[63] *Id.*
[64] CONSTITUTION OF THE REPUBLIC OF UGANDA (1995), art. 22(2); Penal Code Act, Cap. 120, sec. 244 (Uganda).
[65] In the case—Rex v. Bourne—the court held that an abortion would not be "unlawful" if done "in good faith for the purpose only of preserving the life of the mother" and that "if the doctor is of the opinion, on reasonable grounds and with adequate knowledge, that the probable consequence of the continuance of the pregnancy will be to make the woman a physical or mental wreck," then it constitutes acting in preservation of the life of the woman. *See* Rex v. Bourne, [1939] 1 K.B. 687
[66] MINISTRY OF HEALTH (UGANDA), THE NATIONAL POLICY GUIDELINES AND SERVICE STANDARDS FOR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS 4.13 (2006) [hereinafter NATIONAL POLICY GUIDELINES].
[67] CENTER FOR REPRODUCTIVE RIGHTS, BRIEFING PAPER: A TECHNICAL GUIDE TO UNDERSTANDING THE LEGAL AND POLICY FRAMEWORK ON TERMINATION OF PREGNANCY IN UGANDA 6 (2012).
[68] *Id.* at 29.
[69] STAKES ARE HIGH, *supra* note 39, at 32.
[70] *Id.* at 32.
[71] *Id.* at 24.
[72] *Benefits of Meeting Needs*, *supra* note 42, at 5; *See* UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA, *supra* note 33, at 4, 6 & 25.
[73] UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA, *supra* note 33, at 5, 6 & 17.
[74] *Id.* at 5.
[75] Stephen Mallinga & Anthony Mbonye, Maternal Morbidity and Mortality in Uganda 5 (submission to All-Party Parliamentary Group on Population, Development & Reproductive Health—U.K., Dec. 8–9, 2008).
[76] CEDAW Committee, *Concluding Observations: Uganda*, para. 35, U.N. Doc. CEDAW/C/UGA/CO/7 (2010).
[77] *Id*.
[78] CEDAW Committee, *Concluding Observations: Uganda*, para. 147, U.N. Doc. A/57/38 (2002).
[79] *Id*. para. 148.
[80] ELENA PRADA, ET AL., ABORTION AND POST-ABORTION CARE IN UGANDA: A REPORT FROM HEALTHCARE PROFESSIONALS AND HEALTH FACILITIES OCCASIONAL REPORT No. 17 5 (2005), *available at* http://www.guttmacher.org/pubs/2005/05/28/or17.pdf [hereinafter ABORTION & POST-ABORTION CARE IN UGANDA].
[81] *Id*.; *See* UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA, *supra* note 33, at 5.
[82] *Benefits of Meeting Needs*, *supra* note 42, at 3.
[83] ABORTION & POST-ABORTION CARE IN UGANDA, *supra* note 80.
[84] UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA, *supra* note 33, at 4.
[85] For example, abortion performed by a doctor would cost between USD 25 – USD 88 compared to USD 12 – USD 34 if performed by a traditional healer and USD 4 – USD 14 if a woman self-induces: ABORTION & POST-ABORTION CARE IN UGANDA, *supra* note 80, at 6.
[86] STAKES ARE HIGH, *supra* note 39, at 20.
[87] NATIONAL POLICY GUIDELINES, *supra* note 66, at 45.
[88] *Id.* at 20.
[89] Central Intelligence Agency, *The World Fact Book: Uganda*, https://www.cia.gov/library/publications/the-world-factbook/geos/ug.html (last visited Sept. 25, 2014).
[90] NATIONAL POLICY GUIDELINES, *supra* note 66, at 45-47.
[91] *Id.* at 46.
[92] *Id.* at 48.
[93] PROVISION ASSESSMENT, *supra* note 28, at 132.
[94] *Id.* at 136, tbl. 6.13 (2008).
[95] *Id.*
[96] *Ug v Dr. Hassan Nawabul & Anor* (Crim. Case 562/08), *as cited in* DR. MARIA NASSALI, LEGAL ASSESSMENT: UGANDA, A LEGAL AND POLITICAL ANALYSIS OF ABORTION IN UGANDA 14 & 19 (2010).
[97] ABORTION & POST-ABORTION CARE IN UGANDA, *supra* note 80, at 6.

[98] STAKES ARE HIGH, *supra* note 39, at 17.
[99] *Id.*
[100] *Id. at* 16.
[101] WHO AT AL., TRENDS IN MATERNAL MORTALITY: 1990-2013, 4 (2014), *available at* http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf [hereinafter TRENDS IN MATERNAL MORTALITY].
[102] Committee on Economic, Social, and Cultural Rights (CESCR Committee), *General Comment 14, The Right to the Highest Attainable Standard of Health,* para. 21 (22ND Sess., 2000) U.N. Doc. HRI/GEN /1/Rev.5 (2001). *See, e.g.*, *CEDAW Committee Concluding Observations*: *Belize*, para. 56 (1999), U.N. Doc. A/54/38; *Colombia,* para. 393 (1999), U.N, Doc A/54/38; *Dominican Republic*, para. 337 (1998) U.N. Doc A/53/38; *Madagascar* para. 244 (1994) U.N. Doc A/49/38.
[103] CEDAW Committee, *Concluding Observations: Uganda*, para. 35 (2010), U.N. Doc. CEDAW/C/UGA/CO/7.
[104] *Id.* para. 36.
[105] Government Report, *supra* note 30, para. 173.
[106] UGANDA MINISTRY OF FINANCE, PLANNING AND ECONOMIC DEVELOPMENT, MILLENNIUM DEVELOPMENT GOALS REPORT FOR UGANDA 2013 24 (2013) [hereinafter MDG REPORT].
[107] 2006 UDHS, *supra* note 26, at 281.
[108] 2011 UDHS, *supra* note 27, at 238. Another report published in 2012 shows the MMR to be 310, which is still very high and far from Uganda's MDG goal of reducing the MMR to 132. *See* TRENDS IN MATERNAL MORTALITY, *supra* note 104 at 45.
[109] 2011 UDHS, *supra* note 27, at 237, tbl. 15.3.
[110] MINISTRY OF HEALTH, MATERNAL MORBIDITY AND MORTALITY IN UGANDA 1 (2008), *available at* http://www.who.int/pmnch/media/membernews/2011/ugandabackgroundpaper.pdf.
[111] MDG REPORT, *supra* note 106, at 24.
[112] 2011 UDHS, *supra* note 27, at 105.
[113] WHO, Global Health Observatory (GHO), *Antenatal care (at least 4 visits)*, http://www.who.int/gho/urban_health/services/antenatal_care_text/en/ (last visited Sept. 29, 2014).
[114] 2006 UDHS, *supra* note 26, at 121; PROVISION ASSESSMENT, *supra* note 28, at 105 & 107.
[115] PROVISION ASSESSMENT, *supra* note 28, at 114.
[116] *Id.* at 115.
[117] *Id.* at 105.
[118] *Id.* at 112.
[119] 2006 UDHS, *supra* note 26, at 128.
[120] 2011 UDHS, *supra* note 27, at 112.
[121] PROVISION ASSESSMENT, *supra* note 28, at 124.
[122] *Id.*
[123] 2006 UDHS, *supra* note 26, at 125. The 2011 UDHS does not include any update on this data.
[124] *Id.* at 128.
[125] V. Orinda et al., *A sector-wide approach to emergency obstetric care in Uganda*, 91 Int'l J. of Gynecol. & Obstet. 285, 289 (2005).
[126] A.K. Mbonye et al., *Declining Maternal Mortality Ratio in Uganda: Priority Interventions to Achieve the Millennium Development Goal*, 98 Int'l J. of Gynecol. & Obstet. 285, 289 (2007).
[127] May Post MD, *Key Elements of Postpartum Care at the Community Level Based on WHO Guidelines*, CATALYST Consortium Guidelines, http://www.pathfind.org/site/PageServer?pagename=Pubs_Catalyst.
[128] 2011 UDHS, *supra* note 27, at 114.
[129] *Id*.
[130] Human Rights Council, *Universal Periodic Review: Uganda*, para. 112.41, U.N. Doc. A/HRC/19/16 (2011).
[131] REPUBLIC OF UGANDA, MINISTRY OF HEALTH, NATIONAL HEALTH POLICY 1999, para. 2.4 (1999).
[132] Government Report, supra note 30, para. 172.
[133] MINISTRY OF FINANCE, PLANNING AND ECONOMIC DEVELOPMENT, BACKGROUND TO THE BUDGET 2014/2015 FISCAL YEAR: MAINTAINING THE MOMENTUM: INFRASTRUCTURE INVESTMENT FOR GROWTH AND SOCIO-ECONOMIC TRANSFORMATION 104 (2014).
[134] *Id.* at 121.
[135] ABUJA DECLARATION ON HIV/AIDS, TUBERCULOSIS AND OTHER RELATED INFECTIOUS DISEASES, para. 26 OAU/SPS/ABJUA/3 (2001).

[136] *See* STELLA NEEMA ET.AL., ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH IN UGANDA: A SYNTHESIS OF RESEARCH EVIDENCE 21-22 (2004); HARRIET BURUNGI ET AL., SEXUAL AND REPRODUCTIVE HEALTH NEEDS OF ADOLESCENT PERINATALLY INFECTED WITH HIV IN UGANDA 7 (2008).
[137] *See, e.g.*, CEDAW Committee, *Concluding Observations: Dominican Republic*, para. 349, U.N. Doc. A/53/38/Rev.1 (1998); CEDAW Committee, *Concluding Comments: Togo*, para. 29, U.N. Doc. CEDAW/C/TGO/CO/5 (2006).
[138] *See, e.g.*, CEDAW Committee, *Concluding Observations: Chile*, paras. 226–227 (1999), U.N. Doc. A/54/38/Rev.1; CEDAW Committee, *Concluding Comments: Togo*, para. 29 (2006), U.N. Doc. CEDAW/C/TGO/CO/5; CEDAW Committee, *Concluding Observations: Belize*, para. 56 (1999), U.N. Doc. A/54/38; CEDAW Commitee, *Concluding Observations: Nepal*, para. 148 (1999), U.N. Doc.A/54/38.
[139] *See, e.g.*, CEDAW Committee, *Concluding Observations: Burundi*, para. 62 (2001), U.N. Doc. A/56/38; CEDAW Commitee, *Concluding Comments: Cape Verde*, para. 29 (2006), U.N. Doc. CEDAW/C/CPV/CO/6.
[140] *See, e.g.*, CEDAW Committee, *Concluding Comments: Cape Verde*, para. 29 (2006), U.N. Doc. CEDAW/C/CPV/CO/6; CEDAW Committee, *Concluding Comments: Togo*, para. 28 (2006), U.N. Doc. CEDAW/C/TGO/CO/5.
[141] CEDAW *General Recommendation No. 24*, *supra* note 18, para. 23; *see also* CEDAW Committee, *Concluding Comment: Turkmenistan*, para. 30 (2006), U.N. Doc. CEDAW/C/TKM/CO/2; Committee on the Rights of the Child (CRC Committee), *Concluding Observations: Uruguay*, para. 52 (2007), U.N. Doc. CRC/C/URY/CO/2; CESCR Committee, *Concluding Observations: The Kingdom of the Netherlands*, para. 27 (2010), U.N. Doc. E/C.12/NDL/CO/4-5 (2010).
[142] CRC Committee, *General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child*, (33rd Sess., 2003), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 22, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008).
[143] CRC Committee, *Concluding Observations: Antigua and Barbuda*, para. 54 (2004), U.N. Doc. CRC/C/15/Add.247; ESCR Committee, *Concluding Observations: Benin*, para. 42 (2002), U.N. Doc. E/C.12/1/Add.78; Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Interim rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, transmitted by Note of the Secretary-General*, para. 65 (2011), U.N. Doc. A/66/254 (by Anand Grover).
[144] GUTTMACHER INSTITUTE, PROTECTING THE NEW GENERATION IN UGANDA: NEW EVIDENCE ON ADOLESCENT AND SEXUAL AND REPRODUCTIVE NEEDS 23 (2008).
[145] *Id.*
[146] STAKES ARE HIGH, *supra* note 39, at 51.
[147] *See* Josaphat K. Byamugisha et al., *Emergency Contraception and Fertility Awareness among University Students in Kapala, Uganda* 6 Afr. Hlth. Sciences No. 4, 194, 195 (2006).
[148] 2011 UDHS, *supra* note 27, at 67.
[149] WHO & UNFPA, PREGNANT ADOLESCENTS: DELIVERING ON GLOBAL PROMISES OF HOPE 5, 10, 13-15 (2006).
[150] CESCR Committee, Concluding Observations of Reports Submitted by States Parties under Articles 16 and 17 of the Covenant, 35th session, E/C.12/LYB/CO/2 (2006).
[151] African Charter, *supra* note 2, art. 18(3).
[152] Maputo Protocol, *supra* note 2, art. 2(1).
[153] *Id.* art. 2(2).
[154] CEDAW Committee, *Concluding Observations: Uganda*, para. 19 (2010), U.N. Doc. CEDAW/C/UGA/CO/7.
[155] CEDAW Committee, *Concluding Observations: Uganda*, para. 134 (2002), U.N. Doc. A/57/38 (2002).
[156] Human Rights Council, *Universal Periodic Review: Uganda*, para. 111.4 & 111.29 (2011), U.N. Doc. A/HRC/19/16.
[157] JOINT UNITED NATIONS PROGRAMME ON HIV AND AIDS (UNAIDS), 26TH MEETING OF THE UNAIDS PROGRAMME COORDINATING BOARD NON-DISCRIMINATION IN HIV RESPONSES 4-5 (2010), *available at* http://www.unaids.org/en/media/unaids/contentassets/documents/priorities/20100526_non_discrimination_in_hiv_en.pdf.
[158] CESCR Committee, *General Comment No. 14, The right to the highest attainable standard of health (Art. 12)*, (22nd Sess., 2000), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 78, para. 19, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008).
[159] Press Release, International Community of Women Living with HIV & AIDS Eastern Africa, *Uganda's President Yoweri Kaguta Museveni signs HIV prevention and control Bill into law, contradicting evidence, human*

rights, (Aug. 20, 2014), http://www.icwea.org/2014/08/ugandas-president-yoweri-kaguta-museveni-signs-hiv-prevention-and-control-bill-into-law-contradicting-evidence-human-rights-2/.
[160] DRAFT BILL NO. 5, HIV AND AIDS PREVENTION AND CONTROL BILL, 2010, Bills Supp. TO THE UGANDA GAZETTE NO. 24, CL. 13(C), 14 [hereinafter HIV AND AIDS PREVENTION AND CONTROL BILL]; *see also* HUMAN RIGHTS WATCH (HRW), COMMENTS TO UGANDA'S PARLIAMENTARY COMMITTEE ON HIV/AIDS AND RELATED MATTERS ABOUT THE HIV/AIDS PREVENTION AND CONTROL BILL, (2010).
[161] *See* Maputo Protocol, *supra* note 2, art. 14(2)(c); CEDAW, *supra* note 2, art. 10; ICCPR, *supra* note 2; ICESCR, *supra* note 1.
[162] OFFICE OF THE U.N. HIGH COMM'R FOR HUMAN RIGHTS (OHCHR) AND UNAIDS, INTERNATIONAL GUIDELINES ON HIV/AIDS AND HUMAN RIGHTS: 2006 CONSOLIDATED VERSION, (2006) U.N. Doc HR/PUB/06/9, Sales No. E.06.XIV.4 para. 105 (2006), *available at* http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines_en.pdf.
[163] *Id.* para. 96.
[164] BEATRICE WERE AND RICHARD HASUNIRA, COALITION FOR HEALTH PROMOTION AND SOCIAL DEVELOPMENT (HEPS UGANDA), ROUTINE HIV TESTING AND COUNSELING AND ACCESS TO SERVICES FOR THE PREVENTION OF MOTHER-TO-CHILD TRANSMISSION 3 (2010).
[165] HIV AND AIDS PREVENTION AND CONTROL BILL, *supra* note 160, Cl. 23.
[166] *Ugandan Parliament Considers Bill that Would Require HIV Status Disclosure, Provide Some Protections to HIV-Positive People* GLOBAL HEALTH REPORTING (2008), http://www.kaiserhealthnews.org/Daily-Reports/2008/December/15/dr00056085.aspx?p=1.
[167] HIV AND AIDS PREVENTION AND CONTROL BILL, *supra* note 160, Cl. 41
[168] CEDAW Committee, *Concluding Observations: Uganda*, para. 23-24 (2010), U.N. Doc. CEDAW/C/UGA/CO/7.
[169] Government Report, *supra* note 30, para. 94.
[170] *Id*. para. 33.
[171] 2011 UDHS, *supra* note 27, at 239.
[172] *Id*.
[173] 2006 UDHS, *supra* note 26, at 286.
[174] *Id*. at 292.
[175] UGANDA POLICE, ANNUAL CRIME AND TRAFFIC/ROAD SAFETY REPORT, ii (2013).
[176] *Id.* at 5 & 7.
[177] UGANDA POLICE, ANNUAL CRIME AND TRAFFIC/ROAD SAFETY REPORT, APPENDIX I: CRIME BY CRIME (2013).
[178] *Id.*
[179] DIPAK NAKER, VIOLENCE AGAINST CHILDREN: THE VOICES OF UGANDAN CHILDREN AND ADULTS 18, 26 (2005).
[180] *Id.* at 26.
[181] Ann Moore et al., *Coerced First Sex among Adolescent Girls in Sub-Saharan Africa: Prevalence and Context*, 11 Afr. K. Reprod. Hlth. No. 3 62, 63-67 (2007).
[182] Amnesty Int'l, 'I Can't Afford Justice': Violence against Women in Uganda Continues Unchecked and Unpunished 28 (2010) http://www.amnesty.org/en/library/info/AFR59/001/2010/en
[183] *Id.*
[184] STAKES ARE HIGH, *supra* note 39, at 45.
[185] *Id.*