

September 15, 2010

The Committee on the Elimination for Discrimination against Women (CEDAW Committee)

Re: Supplementary Information on Uganda

Dear Committee Members:

This letter is intended to supplement the combined 4th, 5th, 6th and 7th periodic reports of the government of Uganda, scheduled for review by this Committee during its 47th session. The Center for Reproductive Rights (CRR), an independent non-governmental organization that uses the law to advance reproductive freedom as a fundamental human right, and the Uganda Association of Women Lawyers (FIDA-Uganda), an independent non-governmental organization that protects and promotes the human rights and inherent dignity of women and children using law as a tool for social justice, hope to further the work of the Committee by reporting information concerning the rights protected in the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW or “the Convention”).

This letter highlights areas of concern related to violations of women’s and girls’ reproductive and sexual health and rights in Uganda. Despite explicit protections in the Convention, these rights continue to be neglected and, at times, blatantly violated. We wish to bring the Committee’s attention to specific areas of concern, including women’s lack of access to quality maternal healthcare, to family planning services and information, and to HIV services; lack of access to safe abortion and post-abortion care services; and discrimination and sexual violence against women, adolescents and schoolgirls.

I. The Right to Reproductive Health Services and Information (Articles 10, 12, 14(2)(b) and 16(1)(e))

Reproductive rights are a fundamental basis for equality in health and society and a crucial part of the Committee’s mandate under CEDAW.¹ Ratification of the Convention commits states to ensure “[a]ccess to specific educational information to help ensure the health and well-being of families, including information and advice on family planning” [Article 10(h)]; “to ensure, on a basis of equality of men and women, access to health-care services, including those related to family planning [and] to ensure [...] appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary” [(Article 12]; to “take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure... access to adequate health care facilities, including information, counseling, and services in family planning [(Article 14(2)(b)]; and to ensure to women the “rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them

to exercise these rights” [Article 16(1)(e)].

A. Maternal Mortality and Morbidity

The CEDAW Committee has recognized that high maternal mortality² and morbidity³ rates may signify violations of women’s right to life and that “provide an indication ... of possible breaches of [state] duties to ensure women’s access to health care.”⁴ Further, the Committee has stated “that it is the duty of States parties to ensure women's right to safe motherhood and emergency obstetric services and they should allocate to these services the maximum extent of available resources.”⁵

State of Maternal Health in Uganda

The maternal mortality ratio in Uganda is 550 maternal deaths per 100,000 live births, according to statistical data from the UNICEF and the World Health Organization.⁶ This figure is higher than the one provided in the Ugandan government’s report and adjusts for the possible underreporting of maternal deaths in the 2006 Demographic and Health Survey for Uganda (2006 UDHS).⁷ Under the Millennium Development Goals, Uganda has committed to reducing its maternal mortality rate to 132 deaths per 100,000 live births by 2015.⁸ Given the current state of maternal health services in Uganda, it appears highly unlikely that the government will meet this commitment.

For every maternal death in Uganda, six women suffer severe morbidities—such as anemia, infertility, pelvic pain, incontinence and obstetric fistula⁹—that lead to chronic and debilitating ill health and over 100 suffer at least one form of maternal morbidity.¹⁰ These devastating morbidities are caused, in part, by the majority of deliveries occurring outside of health facilities and without skilled attendance, and by delays in seeking and accessing care.¹¹ Morbidity rates are also high within health facilities, indicating the limited capacity, resources, supplies and skills available to clinics and hospitals as well as the barriers in access to care.¹²

The government of Uganda has repeatedly expressed its commitment to improving maternal health. With the goal of “reduc[ing] mortality, morbidity, and fertility and the disparities therein,”¹³ the Uganda Health Sector Strategic Plan III (HSSP III) of 2010 to 2014 is dedicated towards improving reproductive health services in primary and secondary health¹⁴ facilities with a focus on maternal health.¹⁵ The Ugandan government also launched the Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in 2008, which aims to improve the Ugandan healthcare system in the areas of maternal and newborn care.¹⁶ However, as the government’s report states: “[m]aternal health issues are yet to receive the required level of prioritization at both the policy and implementation levels.”¹⁷

The failure to prioritize maternal health issues is reflected most clearly in the government’s budgetary allocations. Although the government’s 2010/2011 budget allocated funds specifically to reduce maternal mortality and improve reproductive health for the first time,¹⁸ the allocations remain insufficient to meet the current need. According to the 2010/2011 health sector budget report, there remains an “unmet (n)ational need for Reproductive Health Supplies estimated at Ushs 7.5 billion”¹⁹ (over 3.3 million USD)—this represents the largest single unmet need for medicines and supplies in

the 2010/2011 budget.²⁰ This unmet need stems, in part, from the recent planned withdrawal of foreign donor support for the health sector; however, the Ugandan government has failed to take appropriate steps to address the funding shortfall—the government has not moved to increase the overall budget allocation for the health sector, which has stagnated at approximately 10% of the annual budget despite Uganda’s commitment to a 15% health sector target under the Abuja Declaration.²¹ Further, according to news reports, maternal and child health receive the least funding within the health sector.²²

The implementation of the Road Map for maternal and reproductive health is slated to expand in 2010 with the establishment of maternal death review committees, the addition of emergency obstetrical facilities in 50 hospitals, and supplementation of basic equipment; however, it remains to be seen what progress can be made in practice given the budgetary constraints on the health sector.²³ No comprehensive tracking of the implementation of the Road Map is available, with only a cursory review provided in the 2010/2011 health budget stating that just 34% of the targeted districts have received the intended allocations without any mention of specific goals or strategies for improving maternal health.²⁴

The Committee has expressed concern when countries fail to report sufficient maternal mortality data²⁵ and recommended that states gather gender-disaggregated data to fully assess women’s reproductive health needs.²⁶ Uganda has failed to structure systems to track maternal deaths and monitor women’s maternal care, including antenatal and post-partum care, across the country.²⁷ The inability to track maternal healthcare data is compounded by the high proportion of women giving birth unattended (10%), attended by a relative (25%) or a traditional birth attendant (23%).²⁸ As a result, there are no mechanisms for following up with women who may need additional care and the lack of monitoring may also lead to inaccurate estimates of the prevalence of specific causes of maternal mortality and morbidity, such as complications from unsafe abortion.

Antenatal Care (ANC)

While data shows that most Ugandan women receive at least some ANC, the quality of that care is often gravely inadequate. Although 94% of Ugandan women who gave birth in the past five years had at least one antenatal care visit, the average gestational age at first ANC visit was 5.5 months.²⁹ This delay in accessing ANC can result in missed opportunities to diagnose, treat and prevent complications. Furthermore, less than half of women receive the minimum number of four ANC visits recommended under Uganda’s minimum service requirements within its maternal health policy.³⁰

The quality of these ANC visits can be far from adequate, with many women never receiving required counseling on family planning, breastfeeding, maternal nutrition, delivery plans, or identifying risk symptoms during pregnancy.³¹ According to the 2007 Uganda Service Provision Assessment Survey (2007 USPAS), just 22% of the facilities that provide ANC services in Uganda carry all of the essential supplies necessary for basic ANC services.³² The majority of facilities lack

the ability to diagnose common pregnancy complications and only 6% of facilities carry the minimum medications required to manage those complications.³³

Delivery Care

Access to, and quality of, delivery care is also a serious problem.³⁴ Although approximately half of all Uganda's health facilities offer basic delivery services, just 5% provide cesarean sections, and only one-quarter are able to provide minimum health services on a 24-hour basis.³⁵ The 2007 USPAS reveals that less than half of facilities are equipped with transportation for maternity emergencies, which creates a significant obstacle in obtaining emergency obstetric care, particularly for the 58% of women who give birth outside of a health facility.³⁶ Less than half of facilities are equipped with the essential supplies to prevent infection during delivery, including soap, running water, disinfectant, and clean latex gloves.³⁷ Just one-third of facilities carry the basic equipment for conducting normal deliveries including scissors, clamps, and a suction apparatus.³⁸ Even those facilities that do carry supplies may be unable to properly sterilize instruments, with just 10% equipped with the requisite sterilization materials.³⁹ Shortages are even more severe in the northern regions of Uganda: the government's failure to implement the Peace, Recovery and Development Plan for Northern Uganda (PRDP), which includes critical maternal healthcare objectives, reflects the ongoing marginalization and neglect of this region in terms of access to reproductive health services.⁴⁰

In addition to the lack of supplies, inadequacies in the number of healthcare providers as well as the skill level of birth attendants pose a grave threat to maternal health. Approximately one half of health facilities are able to offer 24-hour delivery care by any type of trained medical provider, while just 5% have delivery protocols in place.⁴¹ In northern Uganda, just 35% of births are attended by any type of trained professional, and the number of skilled deliveries is the lowest in the country.⁴²

A recent study showed that, of the health facilities expected to be able to offer basic emergency obstetric care (EmOC), fewer than 3% could do so.⁴³ Only 5% of births occur in facilities equipped for emergency obstetric care.⁴⁴ One study showed that 86% of women who should have had some form of obstetrical intervention were unable to obtain it.⁴⁵ Of the few facilities that offer cesarean sections and other emergency procedures, just two-thirds are staffed with anesthetists.⁴⁶ The majority of hospitals and other health facilities are unable to provide blood transfusions, which is a critical barrier to addressing the fact that one quarter of all maternal deaths are caused by severe bleeding without remedy.⁴⁷

The barriers to care in rural areas, caused by the lack of medical staff, transportation, communication and EmOC capabilities, forces women into critical health circumstances. A recent news article highlighted the plight of Salome Nakitanda, who could not afford hospital care or transportation for her eleventh childbirth, barely survived an attempt by a traditional birth attendant (TBA) to provide an emergency cesarean. When complications arose, the TBA performed a cesarean using a kitchen knife after Salome fell unconscious during labor. During the procedure, the TBA sliced through Salome's uterus and bladder. Her baby died, and Salome was finally brought to the hospital where she required long-term treatment, including major reconstructive surgery.⁴⁸ This account illustrates

the severity of preventable complications experienced by women living with minimal access to maternal healthcare.

Post-Partum Care (PPC)

Post-partum care (PPC) is defined by the WHO as the management of care for mother and infant up to 42 days after delivery.⁴⁹ The first 24 hours after delivery is the crucial window for preserving infant and maternal mortality by providing PPC and essential newborn care, with more than one-quarter of infant deaths around the world occurring within the first 24 hours of life.⁵⁰ Yet, according to the 2006 UDHS, about three-quarters of women overall receive no PPC whatsoever⁵¹ with only 11% receiving PPC in the first few hours after birth, and 23% of women receiving PPC in the first two days after birth.⁵² Notably, rural women across Uganda are less likely than their urban counterparts to receive any PPC.⁵³

Obstetric fistula is a severe consequence of the lack of PPC and EmOC combined.⁵⁴ While data on the incidence of fistula in Uganda is poorly documented, estimates range in the number of 140,000 Ugandan women living with the condition, with a higher incidence in rural areas.⁵⁵ Without a coherent national policy or system for tracking obstetric fistula, the burden of treating and preventing this maternal morbidity is unmet. Only a handful of health facilities have trained professionals able to treat fistula, and prevention measures have not been implemented.⁵⁶

B. Access to Family Planning and Information

Access to family planning services and information is central to protecting women's and girls' rights to life and health. In the absence of contraceptive services, women may experience unwanted pregnancies, possibly resulting in death or illness due to lack of adequate healthcare, or they may seek out unsafe illegal abortions that can result in complications or death. Moreover, lack of contraceptive access affects women's right to control their fertility, the right to decide whether to have children and the number and the spacing of children, and the right to self-protection against sexually transmissible infections (STIs) including HIV/AIDS.

In spite of this, access to contraception is undermined by a number of factors, including an inadequate and inconsistent supply of contraceptives, financial barriers, and shortcomings in providing family planning information. As a result, the unmet need for family planning services in Uganda is 41%, according to the 2006 UDHS.⁵⁷ More recent data collected by the Guttmacher Institute shows that this unmet need for family planning skyrockets in the North, where socioeconomic disadvantage and unrest create additional barriers for women, leading to an 84% unmet need for family planning in the region.⁵⁸

The overall contraceptive prevalence rate is just 24% in Uganda⁵⁹ and the use of modern contraceptive methods, namely hormonal birth control, injectables, and condoms, is just 15%.⁶⁰ According to the 2007 USPAS, one-third of births to women between the ages of 15 and 49 were mistimed, with 13% of pregnancies unwanted at the time of conception.⁶¹ The shortfall in family planning services means that Ugandan women on average have two more children than the number

of children they desire.⁶² Lack of access family planning also contributes to maternal deaths by depriving women of the ability to space their children and recover from pregnancies.⁶³

User fees, the unavailability of a preferred contraceptive method,⁶⁴ improper counseling services,⁶⁵ lack of information about contraceptive methods, and absence of supplies necessary to insert certain methods,⁶⁶ contribute to the low contraceptive prevalence in Uganda. Supply shortages of contraceptives in public health facilities are of particular concern. Recent reports show total shortages of contraceptives, leading directly to an increase in unwanted pregnancies and childbirths.⁶⁷ Uganda suffers an acute shortage of condoms, with a supply of just 80-120 million condoms imported by the government yearly, falling far short of the estimated need of over 220 million.⁶⁸ Stockouts of long-term contraceptive methods such as injectables at government facilities are also common, preventing women from accessing their family planning method of choice.⁶⁹ Due to a substantial reduction in foreign donor support for the health sector and the Ugandan government's failure to allocate money to address the resulting funding gap,⁷⁰ Uganda continues to face a shortfall in contraceptive funding of \$3 million USD (about 6 billion Ugandan shillings).⁷¹ Access to family planning supplies is particularly severe in northern Uganda, where conflict has damaged the infrastructure and destroyed basic health services in the region.⁷²

Emergency contraception (EC) is a vital tool in protecting and promoting women's reproductive rights; it is a particularly critical component of care for survivors of sexual violence, who are typically provided EC and post-exposure prophylaxis to reduce the chances of unintended pregnancy and HIV transmission, respectively. Improved access to EC would reduce the cost of unintended pregnancy in Uganda by 75% and would significantly reduce the number of abortions and thereby the number of maternal deaths related to unsafe abortion.⁷³

However, despite the fact that EC was officially introduced by Uganda's Ministry of Health in 1998,⁷⁴ EC use remains low and studies show a lack of awareness of the method.⁷⁵ The government's release of EC was accompanied by widespread media promotion, which provoked significant resistance by local groups, including religious groups.⁷⁶ Despite the media campaigns, less than half of university students surveyed in 2005 had ever heard of EC; this lack of knowledge further increased misinformation about correct usage and amplified fears of the risks of using EC.⁷⁷ The 2007 USPAS shows that the number of women in Uganda who have ever used EC in Uganda is close to zero, while just 18% of health facilities across Uganda report supplying EC.⁷⁸ One study suggests that EC is more likely to be available in the capital, Kampala, than in other parts of the country,⁷⁹ while the 2007 USPAS confirms that EC is more frequently found in hospitals than other types of health facilities.⁸⁰ This data indicates that women in rural areas, or areas that are not in close proximity to a hospital, are even less likely to be able to access EC.

Healthcare workers also lack accurate information about EC and may project unfavorable attitudes towards patients seeking EC, which reduce its use and acceptance.⁸¹ There is insufficient training on the proper use of, and counseling on, EC.⁸² Common misperceptions of EC include the notion that it will inhibit future fertility, encourage sexual promiscuity, and cause extreme side effects.⁸³

In addition, EC should be available to women and girls who have survived rape, particularly in light of the widespread incidence of sexual violence in Uganda. However, women who have survived sexual violence fear the stigmatization of revealing their experience, and also may face delays in accessing EC that undermine its effectiveness, particularly in the northern regions where sexual violence is rampant and services are minimal.⁸⁴

C. Adolescent Reproductive Health

The CEDAW Committee has asked states to pay particular attention to “the health education of adolescents, including information and counseling on all methods of family planning,”⁸⁵ and has specifically recommended that states parties, including Uganda, develop preventive programs to address the problem of high rates of adolescent⁸⁶ pregnancy,⁸⁷ and unsafe abortion.⁸⁸ The Committee has also recognized sexual abuse of girls by older men as a violation of their reproductive rights⁸⁹ and has expressed grave concern over violence and against girls in conflict zones,⁹⁰ highlighting the importance of redress for civilian victims of sexual violence during armed conflict.⁹¹

Sexual and reproductive health information and services for adolescents remain drastically inadequate in Uganda. Adolescents begin sexual activity early in Uganda compared to other Sub-Saharan African countries⁹² and, while general awareness of HIV is widespread, a high percentage of adolescents are not aware of other sexually transmitted infections (STIs) and in-depth knowledge of how to prevent HIV and other STIs remains poor.⁹³ Adolescents lack knowledge of proper condom use and are at particular risk of engaging in poor preventive behaviors, which in turn increase the risk of transmitting HIV.⁹⁴ The underlying reason for risky behaviors and misinformation amongst adolescents is the failure of the Ugandan government to tailor services and programs to adolescent needs.⁹⁵

Adolescent women remain at particular risk of HIV transmission. Women aged 15 to 24 are more than twice as likely as their male counterparts to have HIV/AIDS.⁹⁶ This disproportionate risk to women is rooted in social and cultural factors that lead to women beginning sexual activity at younger ages, often due to early marriage,⁹⁷ as well as the prevalence of coerced sex and age disparities between young girls who have sex with older men.⁹⁸ Particularly vulnerable subgroups of adolescent women include street children, sex workers, displaced persons, and orphans.⁹⁹ Health centers are not sufficiently targeted towards young people,¹⁰⁰ and much of the sexual health information and education that empowers teenagers to protect themselves from HIV is limited to the school context, making it unavailable to young women who are 6 times more likely not to attend school than their male counterparts.¹⁰¹ Because sex education in schools is neither comprehensive nor age-targeted, many students are unable to access information about HIV risks and prevention until after they become sexually active.¹⁰²

The lack of critical adolescent sexual and reproductive health information and services also contributes to high rates of teenage pregnancy: Uganda’s adolescent pregnancy rate is amongst the highest in the world.¹⁰³ Over one-quarter of young women have begun childbearing by age 17, with close to 60% of women having given birth to one or more children by age 19.¹⁰⁴ The high rate of

births to teenage mothers is a serious concern because of the association between young maternal age and greater risk of infant and maternal mortality and morbidity. According to the Uganda National Development Plan, the culture of early marriages amongst girls increases the rate of early pregnancies and is partly responsible for the country's high maternal mortality rate.¹⁰⁵ The median age of marriage for girls in Uganda is 17.8 years.¹⁰⁶ Early marriage is associated with higher fertility rates and a longer period of childbearing thereby exposing women to repeated maternal mortality and morbidity risks.¹⁰⁷

High rates of teenage pregnancy may also be attributed, in part, to high rates of sexual violence against young girls and women in Uganda—particularly in schools. In Uganda, 23% of girls reported that their first sexual encounter was forced, and studies have shown a link between early coercive sex and failure to use preventive measures such as condoms for fear of violence.¹⁰⁸ A disturbing proportion of this sexual violence against girls occurs in schools. In one recent study, over 75% of Ugandan children between the ages of 8 and 18 reported some form of sexual violence or harassment, with 24% of children reporting that this violence occurs mainly in school, and 34% reporting that it occurs both at home and at school.¹⁰⁹ Further, girls are the most likely targets of sexual violence and have a higher probability of suffering ill health effects as a consequence of sexual violence, including drug use and risky sexual behavior.¹¹⁰ A 2008 study revealed that 8% of 16 and 17 year old Ugandan girls have had sex with their teachers.¹¹¹ Teachers often lure girls by promising good grades or threaten them to prevent them from reporting the violence. Sexual abuse in schools also results in poor school performance, unintended teen pregnancy, absenteeism, and early drop-outs from school.¹¹² Violence against women and girls is particularly extreme in the northern districts, where thousands of girls were abducted to be used as sex slaves during the conflict, and where the lack of police officers means that there may be no legal recourse for victims of rape, defilement, assault and other forms of sexual violence.¹¹³

The lack of access to sexual and reproductive health services and information and the high rates of sexual violence mean that many Ugandan adolescents are forced to deal with unwanted pregnancies. In its 2002 Concluding Observations for Uganda, the Committee expressed its concern about the impact of adolescent pregnancy on “girls’ enjoyment of the rights in the Convention, particularly in the spheres of education and health.”¹¹⁴ A 2005 report documents the continuing stigma and discrimination experienced by pregnant adolescents and its impact on their rights to health and education: pregnant young women—particularly those who are unmarried—are subject to violence by family members and may be sent away from their homes, are expelled from school, and receive “rude, abusive and threatening” treatment from healthcare workers when they attempt to seek care in connection with their pregnancy.¹¹⁵ These experiences of stigma and discrimination push some young women to procure unsafe abortions,¹¹⁶ placing their lives and health at serious risk. The Committee acknowledged this fact in its previous Concluding Observations for Uganda, expressing concern at “the high rate of maternal mortality among teenage girls, particularly in the rural areas, frequently as a result of clandestine abortion.”¹¹⁷

D. Unsafe Abortion and Post-Abortion Care

The Committee's General Recommendation 24 states that "barriers to women's access to appropriate healthcare include laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures."¹¹⁸ The Committee has often framed restrictive abortion laws as a violation of the rights to life and health.¹¹⁹ As such, it has asked states to review legislation that makes abortion illegal¹²⁰ and recommended that states remove punitive provisions for women who undergo abortion,¹²¹ in line with the Committee's General Recommendation 24 and the Beijing Declaration and Platform for Action.¹²² The Committee also explicitly calls for the removal of impediments to women's access to lifesaving health services (such as high fees, spousal authorization, or punitive provisions imposed on women who undergo abortions) be removed.¹²³

Unsafe abortion is one of the most easily preventable causes of maternal death and disability. Unsafe abortion also causes grave morbidities, and women may experience long-term harm such as uterine perforation, chronic pelvic pain, or infertility.¹²⁴ Each year an estimated total of 297,000 induced abortions (both legal and illegal) are performed in Uganda with approximately 1,200 women dying each year from unsafe abortions and nearly 85,000 women treated for complications.¹²⁵ Although there are no official statistics on abortion or abortion complications, it is clear that unsafe abortion is a leading cause of maternal morbidity and mortality in Uganda.¹²⁶ A recent submission from Uganda to the All-Party Parliamentary Group on Population, Development and Reproductive Health puts the percentage of maternal deaths attributable to unsafe abortion at 26%.¹²⁷

Despite Uganda's stated commitment to improving maternal health, its abortion law and policies are characterized by restrictiveness and a lack of clarity. The Penal Code classifies abortion as a felony and criminalizes abortion except to save the life of the pregnant woman.¹²⁸ The Ugandan constitution states that "[n]o person has the right to terminate the life of an unborn child *except as may be authorized by law*" (emphasis added).¹²⁹ Domestic judicial interpretation of abortion rights in Uganda has acknowledged that "unsafe abortion is an infringement of women's rights" that must be prevented and addressed, despite maintaining that abortion is illegal.¹³⁰ Although Uganda recently ratified the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol),¹³¹ which supplements the African Charter and provides broad protections for women's human rights, the government reserved on Article 14(1)(a), which guarantees women the right to control their fertility.¹³² The government further reserved on Article 14(2)(c), which would have expanded access to safe abortion services to include exceptions to preserve the woman's health and in cases of rape and incest.¹³³

Uganda's National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights (Reproductive Health Guidelines) detail an expanded scope of circumstances permitting legal abortion, such as sexual violence and incest, and outline comprehensive abortion and post-abortion care standards.¹³⁴ In practice, however, doctors and other trained providers are reluctant to provide the comprehensive services outlined in the Guidelines, unwilling to be potentially subject to criminal liability under the Penal Code. Doctors may even refuse to perform post-abortion care, and women are likewise afraid to seek professional abortion-related care, for fear of being reported to the

police.¹³⁵ The stigma and fear associated with abortion affects funding allocations as well: one recent study on health spending in Uganda concluded that “highly sensitive issues, such as abortion . . . are consciously being neglected and under-funded.”¹³⁶

The poorer a woman is, and the more rural her location, the less likely she is to seek abortion services from a trained or licensed healthcare professional. Poorer women are more likely to have clandestine abortions, often in unsanitary conditions at the hands of untrained practitioners, greatly increasing the risk of abortion-related complications.¹³⁷ Less safe providers perform over half of the abortions occurring in poorer, rural areas throughout Uganda.¹³⁸ A survey of healthcare providers found that the percentage of abortions performed by doctors drops from 50% for non-poor urban women to 10% for poor rural women.¹³⁹ Girls are also less likely to be able to access and afford safe abortion services and may feel additional pressure to terminate a pregnancy because of the social stigma of pregnancy and the difficulties of continuing their education. However, even abortions performed by trained healthcare providers may still be unsafe because, as one doctor at Makerere University explained, “[m]any of our doctors have not been well trained to offer safe methods or are working under unsafe conditions.”¹⁴⁰

Uganda’s health facilities are also poorly equipped to manage post-abortion care (PAC). Vacuum aspirators¹⁴¹ and dilation and curettage (D&C)¹⁴² kits—supplies critical to the provision of PAC—are available in 22% and 14%, respectively, of the health facilities offering delivery services.¹⁴³ Delivery 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 USPAS.¹⁴⁴ Private facilities are more likely than government facilities to offer appropriate PAC services, but the cost of these services makes them prohibitive for many women.¹⁴⁵ A survey of Ugandan women also suggests that women do not seek medical treatment for abortions or related complications because they fear negative reactions and judgment from healthcare providers.¹⁴⁶ Only 51% of poor rural women who suffer abortion complications seek medical assistance.¹⁴⁷ Even when women do seek post-abortion care, “the drugs, equipment, and skills are insufficient” noted an Assistant Commissioner for Reproductive Health in the Ministry of Health.¹⁴⁸ The lack of access to safe abortion services increases the burden on the Ugandan healthcare system, particularly public hospitals which treat the most severe abortion-related complications,¹⁴⁹ and places Ugandan women at risk of long-term disabilities or death.

A recent news article demonstrates the dire harm caused by restrictive abortion laws and women’s lack of access to post-abortion care. In the article, a senior midwife at Jinja Regional Referral Hospital maternity wing in eastern Uganda reports that the majority of the cases treated at the maternity wing are complications from abortion because “abortion is hurriedly and secretly done”—according to the midwife, they receive approximately 30 abortion cases per week.¹⁵⁰ Women who live in the county but cannot reach Jinja Hospital may turn to their local health center; however, many lower level health centers in the district “do not have the medical supplies or sufficiently trained health professionals to provide post-abortion care.”¹⁵¹ As a result, girls with cases of incomplete abortion who seek care locally often die because they seek assistance too late, because

ambulances are scarce and taxi drivers refuse to transport them to Jinja once sepsis has caused a foul odor, and because the health centers lack critical supplies, such as “strong antibiotics for abortion cases,” to treat post-abortion care patients.¹⁵²

E. STI and HIV Services for Women

Accurate information on prevention and treatment of sexually transmitted infections (STIs) is a key component of sexual and reproductive health. The CEDAW Committee has noted that “issues of HIV/AIDS and other sexually transmitted diseases are central to the rights of women and adolescent girls to sexual health,” and has urged states to ensure “without prejudice and discrimination, the right to sexual health information, education and services for all women and girls.”¹⁵³

Uganda has failed to prevent discrimination against women and girls on the basis of HIV status and, in fact, has proposed legislation that would exacerbate such discrimination. Uganda has also failed to provide adequate health services and access to preventive measures, including family planning and information, to empower women against HIV/AIDS and other STIs.

HIV/AIDS Rates

Despite the praise that Uganda has received as a country that successfully implemented a campaign against HIV/AIDS throughout the 1990s, Uganda still faces a severe HIV epidemic.¹⁵⁴ By 2007, a cumulative total of approximately 2.6 million people in Uganda had contracted HIV.¹⁵⁵ Of these people, approximately 1.6 million have died and roughly 1 million are living with HIV.¹⁵⁶ In addition, about 1.2 million children have been orphaned by AIDS.¹⁵⁷ The current HIV prevalence rate in Uganda is estimated to be 6.4 %, ¹⁵⁸ with prevalence higher among adult women (7.5 %) as compared to men (5 %).¹⁵⁹ Additionally, prevalence rates are higher among young women aged 15 – 24 (3.9 %) than young men of the same age (1.3 %).¹⁶⁰ While, overall, women living in urban areas have a significantly higher risk than women in rural areas, the HIV prevalence rate in the rural northern region is particularly high for women.¹⁶¹ Sex workers are the population at highest risk, with an overall HIV prevalence of 47.2%.¹⁶²

Recently, Uganda has experienced an increase in the number of new HIV cases reported,¹⁶³ which may be partially attributable to the government’s emphasis on abstinence-based prevention programs, which are detrimental to Ugandan women.¹⁶⁴ Uganda lacks a comprehensive approach to addressing HIV/AIDS that incorporates the prevention of mother to child transmission, including through family planning, the prevention and treatment of STIs, and other innovative interventions to supplement the abstinence until marriage principles.¹⁶⁵

An emphasis on abstinence until marriage is both flawed and dangerous since women are often forced into non-consensual sexual relations and marriage itself can actually be a risk factor for contracting HIV.¹⁶⁶ Data demonstrates that men are increasingly engaging in extramarital sex; at the same time, married individuals are “least likely to use condoms.”¹⁶⁷ Significantly, most married couples are sero-discordant (meaning that one partner is HIV-positive and not the other), thus

married persons are at particular risk of transmission, indicating that counseling, testing and education measures must be tailored to the needs of these couples.¹⁶⁸

As in other countries, people living with HIV suffer stigma and discrimination in Uganda¹⁶⁹ and HIV-positive women are often victims of violence because of their HIV status.¹⁷⁰ Despite the existence of HIV/AIDS programs, which aim to fight such attitudes and to encourage those living with HIV to seek treatment and support, attitudes have been slow to change in Uganda. As a result of this persistent stigma and a fear of violence, many women fear learning and disclosing their HIV status, because if their partners accuse them of bringing HIV into the home, evict them from the home, or subject them to domestic violence.¹⁷¹ In 2008 alone, five cases were reported of women being murdered by their husbands once they learned that their wives were HIV-positive.¹⁷²

Harmful Implications of the HIV and AIDS Prevention and Control Bill, 2010 on Women's Health

The Ugandan Parliament was considering a draft bill titled the “HIV and AIDS Prevention and Control Bill, 2010” [the HIV Bill], which introduced before Parliament on May 19, 2010 and tabled for the first reading.¹⁷³ While the bill is currently shelved due to intensive advocacy against it, the fact that such legislation progressed as far as it did is highly problematic. The Ugandan parliament introduced this legislation in response to research findings demonstrating that Uganda's HIV prevalence rate had stagnated at around 6.5% and indicating that an increasing number of infections occurred among married couples.¹⁷⁴ Several of the HIV Bill's provisions threaten to negatively impact HIV-positive women, including provisions that criminalize transmission of HIV/AIDS, permit non-consensual disclosure of one's status, and allow mandatory HIV testing without patient consent in certain circumstances. The HIV Bill provides for “(r)outine HIV testing” for victims of sexual offences, pregnant women, and partners of pregnant women without an informed consent requirement¹⁷⁵ and people “convicted of an offence involving prostitution” are “subjected to HIV testing for purposes of criminal proceedings and investigations.”¹⁷⁶ No guidance is given in any of these circumstances on informed consent leading human rights experts to interpret these clauses as putting in place mandatory testing.¹⁷⁷

Compulsory testing of pregnant women may discourage women from seeking healthcare, which, in turn, would undermine the Ugandan government's ability to prevent the spread of HIV and make improvements in available maternal healthcare. 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 individual¹⁷⁸ which can result in “reduced participation and increased alienation of those at risk of infection.”¹⁷⁹ Even when pregnant women learn their HIV status, appropriate treatment is often not available. PMTCT treatment is only integrated into ANC and delivery services at 43% of health facilities in Uganda.¹⁸⁰ 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.

Mandatory testing of sexual crimes victims risks increasing harm to these victims, as well as marginalizing women and sex workers in particular who are more likely to fall under this category.¹⁸¹ Mandatory testing will foster discrimination in the healthcare system against these populations and increase the stigma faced by survivors of sexual violence, which creates barriers to HIV treatment and discourages the reporting of sexual crimes.

Clause 23 of the HIV Bill allows healthcare providers to release the results of an HIV/AIDS test to a patient's sexual partners without the patient's consent.¹⁸² Nonconsensual disclosure of women's status exposes them to stigma, discrimination, and violence.¹⁸³ If women fear that healthcare providers will disclose their HIV status to their partners without their consent, they may be discouraged from seeking healthcare services, which could undermine the government's public health initiatives around HIV and reproductive health.¹⁸⁴

Clause 41 of the HIV Bill criminalizes the intentional transmission of HIV and provides for harsh criminal penalties, exposing HIV-positive women to further risks of human rights violations.¹⁸⁵ Since women are more likely to learn of their sero-status because HIV testing is routinely provided as part of prenatal healthcare, they are more vulnerable to charges from their male partners of intentional HIV transmission. Additionally, imposing criminal penalties on the intentional transmission of HIV stigmatizes people living with HIV, who may choose to forego HIV treatment and care for fear of incurring criminal liability in the process. Thus, the criminalization of HIV transmission is ineffective in combating the spread of HIV; instead, it threatens to undermine HIV prevention efforts and exacerbate the stigma and discrimination already experienced by people living with HIV, particularly women, when they seek access to health facilities.

Prevalence and Treatment of Other STIs and Cervical Cancer

The CEDAW Committee has expressed concern over rising rates of sexually transmitted infections (STIs),¹⁸⁶ with particular concern regarding higher STI infection rates for women than men.¹⁸⁷ The Committee has also asked governments to take a human rights-based¹⁸⁸ and gender sensitive¹⁸⁹ approach against HIV and STIs, and has previously asked Uganda to implement practical prevention methods including promoting condom use.¹⁹⁰ The prevalence of STIs in Uganda is extremely high. Within the age 15-49 bracket, 49% of women and 38% of men have the herpes simplex 2 virus, 10% of men and women have Hepatitis B and 3% of men and women have syphilis.¹⁹¹ Many are unaware that they have an STI and amongst previously untested persons who have ever been sexually active but reported no symptoms, half of women and 40% of men tested positive for herpes.¹⁹²

Uganda also has amongst the highest prevalence rates and lowest survival rates for cervical cancer, the most common cause of death for Ugandan women outside the childbearing age bracket.¹⁹³ Only 13% of women survive cervical cancer in Uganda,¹⁹⁴ as measured by the five-year age-standardized relative survival. The main factors contributing to this excessive death rate from cervical cancer are the failure to detect cancer or precancerous cell changes at an early stage,¹⁹⁵ and poor quality and access to healthcare services.¹⁹⁶ Prior studies have also found that the great majority of cervical cancer patients in Uganda have HPV, with HPV type 16 present in 53% of women with cervical

cancer.¹⁹⁷ Without comprehensive vaccination programs and screening, the number of women developing and dying from cervical cancer will only increase.

II. The Right to Be Free from Discrimination, Including Gender-Based Violence (Articles 1, 2, 12, 14, and 16)

The Convention defines discrimination against women as “any distinction, exclusion or restriction made on the basis of sex which has the *effect or purpose* of impairing or nullifying the recognition, enjoyment or exercise by women ... of human rights and fundamental freedoms.”¹⁹⁸ Accordingly, the Committee has determined that an act “directed against a woman because she is a woman or that affects women disproportionately” constitutes gender-based discrimination.¹⁹⁹

States are obligated under CEDAW to take steps to eliminate sex-based discrimination by both public and private actors.²⁰⁰ This requirement of non-discrimination permeates all of Uganda’s duties under CEDAW, including the obligation “to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services” [Article 12(1)]; the obligation “to eliminate discrimination against women in rural areas in order to ensure ... access to adequate health care facilities” [Article 14(2)]; and the obligation “to eliminate discrimination against women in all matters related to marriage and family relations [and to] ensure, on a basis of equality of men and women ... [t]he same rights to decide freely and responsibly on the number and spacing of their children” [Article 16(1)(e)]. In addition, the CEDAW Committee has affirmed that states have an obligation under the Convention “to eliminate all forms of violence against women,” because discrimination against women includes gender-based violence.²⁰¹ Women seeking healthcare services in Uganda encounter discrimination based on their income, age [see Adolescent Reproductive Health section], gender, place of residence and occupation.

A. Discrimination in Healthcare

Healthcare costs—which can include the cost of the health good or service itself, fees for transportation, food, supplies or drugs that must be purchased and brought to the facility, and informal board charges—can prevent or delay women from accessing services, and can impose additional health risks and hardship. User fees, in general, tend to hit women harder than men. Yet, user fees present a considerable barrier to women’s access to maternal healthcare and family planning services in Uganda.

Across each area of maternal healthcare provision in Uganda, grave disparities of access and quality distinguish government and private health facilities. Although private facilities are more likely to carry essential medical supplies and equipment, they are also more likely to charge user fees. Where fees are charged, facilities fail to monitor and publicize fee schedules.²⁰² The ability to pay is cited by women as the greatest obstacle to their ability to access maternity care, and rural women are disproportionately impacted by user fees.²⁰³ In addition, although care is supposed to be free of charge in the public health sector,²⁰⁴ in practice user fees, as well as fees for medical supplies, tests,

registration fees and medication, are frequently levied.²⁰⁵ As a consequence women seeking maternal healthcare²⁰⁶ are forced to pay.²⁰⁷

A similar situation applies to women seeking family planning services.²⁰⁸ The 2006 UDHS documents that contraceptives are far more likely to be free in public health facilities than in private facilities and, where fees are charged for contraceptives in the public sector, prices are typically lower than in the private sector.²⁰⁹ However, despite the greater affordability of public sector services and goods, the greatest single source of contraceptives for Ugandans is private hospitals and clinics.²¹⁰ The government's failure to commit funds to family planning commodities, and the subsequent family planning supply shortages, shift the responsibility to meet women's family planning needs to the private sector, which is more likely to charge user fees.²¹¹ These costs are prohibitive for many in a country where the gross national income per capita is just \$420²¹² and over 75% of the population lives on less than \$2 a day.²¹³

Women living in poverty, in rural areas, and particularly in the conflict-stricken northern regions of Uganda, face the most extreme barriers to protecting and fulfilling their reproductive and sexual health and rights.²¹⁴ For example, according to the 2006 UDHS, rural women are more likely than urban women to report challenges in accessing healthcare—60.2% of rural women cite distance to the health facility as a challenge, compared to 26.1% of urban women; similarly, 54% of rural women report the need for transportation as an obstacle, versus 23.9% of urban women.²¹⁵ In addition, some internally displaced persons camps in the north have reported the complete unavailability of medication to prevent mother-to-child transmission of HIV and shortages of antiretrovirals (ARVs).²¹⁶

Sex workers also contend with additional barriers to access, and evidence shows that sex workers face the highest risk of HIV infection (47.2%) while just 58% of clients report using condoms.²¹⁷ Sex workers face discrimination by health workers and police alike, which discourages them from accessing essential reproductive and sexual healthcare services.²¹⁸

Sexual minorities also encounter discrimination in access to healthcare--a recent report on healthcare spending in Uganda found that reproductive health services for sexual minorities are “consciously being neglected and under-funded,” evidence of the discrimination and stigma faced by this marginalized population.²¹⁹

Finally, gender inequities also form a major obstacle to women's access to sexual and reproductive health services in Uganda. Nearly 40% of women say that their male partner plays the primary decision-making role over their healthcare, and half of men believe it is a man's role to decide on the number of children a couple will have.²²⁰ This gender inequity impacts women's ability to prevent pregnancy and the transmission of STIs and also affects women's ability to seek assistance for complications in pregnancy and childbirth.²²¹

B. Gender-Based Violence and Discrimination

The Committee has previously expressed concern about the high incidence of sexual violence against women in Uganda,²²² calling on Uganda to address the persistent patriarchal patterns of behavior and “the existence of stereotypes relating to the role of women,” which perpetuate violence and discrimination against women.²²³ However, gender-based violence, particularly sexual violence against women and girls, continues to be a serious and pervasive problem in Uganda.

According to the 2006 UDHS, 68% of ever-married women experienced some form of violence by their husband or intimate partner.²²⁴ Death from domestic violence in Uganda has increased in recent years, with 165 cases reported to the Uganda Police in 2009, marking a 20% increase in just one year.²²⁵ 60% of women suffer physical violence, with their husband or partner as the most common perpetrator.²²⁶ Over half of ever-married women are subject to physical or sexual violence and women who are married and between the ages of 25 and 39 are at greatest risk of violence.²²⁷ Cultural and societal views perpetuate violence against women, with 70% of women believing that physical violence against women is justifiable in at least certain circumstances.²²⁸

According to the same 2006 UDHS survey, approximately one-quarter of women aged 15 to 49 reported that the first time they engaged in sexual intercourse was against their will.²²⁹ Additionally, about four in ten Ugandan women experience sexual violence during their lifetimes.²³⁰ Of those women who do suffer sexual violence, approximately 66% experience such violence at the hands of a current or former husband or partner.²³¹ Yet, despite these high rates of sexual violence, the Sexual Offences Bill remains pending in Uganda’s Parliament, six years after it was first introduced.²³²

Victims of sexual violence are exposed to the possibility of contracting HIV from their assailant. Yet, healthcare system weaknesses mean that survivors of sexual violence have difficulty accessing the post-exposure prophylaxis (PEP) necessary to prevent contracting HIV following a sexual assault.²³³ This problem is particularly acute in remote areas of northern Uganda where doctors are reluctant to work.²³⁴ As the staff member of one women’s rights organization explained, “PEP could be available in health units, but when we refer the survivors there for medication, they find no one to help them. There is a shortage of doctors.”²³⁵ Healthcare workers have been reluctant to serve the population in northern Uganda in recent years due to active conflict, resulting in a desperate lack of reproductive and sexual health services.²³⁶

Even when victims do report rape, the Ugandan judicial system fails to pursue justice and women face indifference to these crimes and impunity for their assailants. A survey of rape and defilement cases in northern Uganda revealed that fewer than 2% of reported rape cases resulted in a conviction, and less than 6% of defilement cases resulted in a conviction.²³⁷ A significant number of victims cited the total lack of affordable legal assistance, coercion by perpetrators, and backlogged courts as reasons why cases were dropped.²³⁸

In addition, public attitudes about rape and sexual violence are amplified by the media, which exacerbates the stigma against women and survivors of sexual violence. For instance, in 2009, a

Ugandan doctor who was raped and robbed was then publicly humiliated by the press—a news source wrote an article graphically discussing her rape and disclosing her name to the public, perpetuating the stigma and discrimination she already faced.²³⁹

C. Harmful Traditional Practices

The Status of Women and Views on Marriage

The CEDAW Committee has issued guidelines on equality in marriage and requires states parties to apply the principles of equality and justice regardless of the particular legal system, religion, custom or tradition applicable in the country or region.²⁴⁰ The Committee has expressed concern that custom, tradition, and the failure to enforce national constitutions and laws have resulted in instances of polygamous marriage and forced or arranged marriages.²⁴¹ In its General Recommendation 19, the Committee defines forced marriage as a form of violence against women and as perpetuating their subordinate role in society.²⁴²

Polygamy is legal in Uganda and women lack legal recourse to prevent their husband from marrying additional wives.²⁴³ The power to make decisions regarding health, reproduction, and children remains in the hands of men.²⁴⁴ This power imbalance poses increased health risks, including the risk of contracting HIV and other STIs, by depriving women of the power to negotiate condom use. The Marriage and Divorce Bill, which includes provisions on equality in marriage and in the family, addresses “women’s right to negotiate sex on the ground of health,” would go a long way towards addressing these gender inequalities.²⁴⁵ However, despite repeated attempts by women’s groups to push for the bill’s passage, Parliament has repeatedly shelved the bill and delayed the legislative process for almost two decades.²⁴⁶

Early and Forced Marriage

The CEDAW Committee has identified 18 as the appropriate legal age of marriage for both men and women²⁴⁷ and has rejected arguments in support of an earlier marriage age for girls because of the associated health risks.²⁴⁸ The minimum legal age for marriage in Uganda is 18 for both men and women; however, in practice, the cultural preference for early marriage is widespread, with the 2006 UDHS estimating that over 15% of girls between 15 and 19 years of age were married, widowed or divorced.²⁴⁹

Early marriage exposes women to increased risks of maternal mortality and morbidity. Younger mothers are at particular risk for complications such as obstetric fistula because pelvic growth is not complete.²⁵⁰ Adolescent women are less likely to seek antenatal care and more likely to suffer complications and require cesareans; complications from pregnancy, abortion and childbirth remain the leading cause of death for women between the ages of 15 and 19.²⁵¹ Early marriage also exposes girls to coerced sex and studies show that younger women are more susceptible to coerced sex.²⁵²

In northern Uganda, particularly in refugee camps and settlements, the practice of abducting and forcing young girls to marry and bear children has been a systematic violation of women's rights.²⁵³ Thousands of girls and young women were abducted and forced into marriage and sexual service by members of the Lord's Resistance Army during the conflict, and the practice of systematic sexual violence and forced marriage has continued since the cessation of hostilities.²⁵⁴ Half of all forced wives gave birth to children, of which one quarter gave birth at age 18 or younger, and nearly half of LRA commanders had five or more forced wives given to them as a reward for their participation in the violence.²⁵⁵

The practice of early marriage is sometimes a response to cover the stigma faced by girls who have already been sexually abused. In this region, conflict has disrupted society such that rape is now utilized in some instances to force girls and adolescents into marriage²⁵⁶ and these forms of violence against women have become normalized. Young women who were abducted, then forced into marriage and childbearing, and later return with their children, are less likely to access education by one third; they are also less likely to be employed and are likely to earn less than their counterparts who were not abducted.²⁵⁷ These young women also face the highest rates of sexual violence in their communities and there continues to be little or no legal remedy available to these women.²⁵⁸

Female Genital Mutilation

The CEDAW Committee has identified female genital mutilation (FGM) as a threat to women's rights to life and physical integrity as well as social and economic equality²⁵⁹ and underscored states' responsibility to stop this form of violence against women.²⁶⁰ The Committee has also identified the practice as discriminatory in its concluding observations to the government of Uganda.²⁶¹ FGM is correlated with early marriage, earlier age of first childbirth, and increased rates of HIV transmission.²⁶² FGM has been recently banned in Uganda²⁶³ and also found to be inconsistent with Uganda's constitution and international treaty obligations in a recent constitutional court decision citing the deaths correlated with the practice of FGM.²⁶⁴ Despite these legal prohibitions, there is a lack of sensitization and awareness-raising to support the implementation of the law in regions of Uganda where girls are at the greatest risk of community coercion and pressure to undergo FGM.²⁶⁵ Uganda continues to face challenges in implementing the FGM ban because of the strong social stigma still associated with not undergoing FGM—resulting in the abuse and exclusion of women who have not undergone FGM.²⁶⁶

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

Maternal Health and Family Planning Services

1. What steps is the government taking to ensure implementation of the 2008 Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda 2006-2015? Has the government outlined quantifiable goals with a monitoring and evaluation system to track the implementation of the Road Map?

2. What steps has the government taken or does the government plan to take to ensure that all healthcare services including medication and supplies that are intended to be free of charge do not incur user fees in practice? What other measures are being taken to eliminate the financial barriers faced by women seeking family planning, maternal health care and other services?
3. What measures are being taken to ensure sufficient supplies of family planning and contraceptive methods, particularly the long-term methods preferred by women in Uganda, to avoid the stockouts of 2010? What is the government doing to ensure its stock of condoms is sufficient to meet the national need? What steps is the government taking to improve awareness about, and the availability of, emergency contraception?
4. What does the government plan to do to address obstetric fistula and remedy the fact that currently there is no national policy, no tracking system, and a limited number of trained professionals able to treat obstetric fistula?
5. What programs has the government implemented to improve the tracking and monitoring of maternal and reproductive health care, specifically to improve the number of women receiving the recommended antenatal care and to gather information about the incidence and causes of maternal mortality and morbidity? What measures have been taken to improve data collection related to the incidence of unsafe abortion?

Access to Safe and Legal Abortion

6. Is there any law that operationalizes the constitutional provision on abortion stating that “[n]o person has the right to terminate the life of an unborn child *except as may be authorized by law*”? What steps are being taken to reconcile the criminal law exception for abortion to save the life of the woman with the broader range of exceptions in the Reproductive Health Guidelines? How will the government ensure effective implementation of the provisions on access to safe abortion in these guidelines? What steps will the government take to ensure that healthcare providers are aware of, and adhering to, these guidelines?
7. What measures has the government taken to address the stigma and discrimination associated with unsafe abortion and to encourage women with abortion complications to seek medical care? How will the government address the lack of trained staff and equipment and the limited funding allocations for abortion-related services?
8. What are the Ugandan government’s reasons for having reservations to the Maputo Protocol? In view of the current East African Community, does the reservation affect the harmonization of the national legislation, particularly where Tanzania ratified without reservations? Are there any plans to lift the reservations? When is the national legal framework for safe abortion going to be put in place or clarified? What measures have government put in place to ensure the rights of children who are born as a result of sexual violence and abandoned by both parents?

Adolescents

9. What measures has the government taken to improve sexual health education, particularly for adolescents and youth? How does the government plan to ensure that youth who do not attend school receive comprehensive sexual health education?
10. What efforts have been taken to reduce the high rates of adolescent pregnancy? What steps have been taken to address early marriage and forced sex as underlying factors in the incidence of adolescent pregnancy in Uganda?
11. What measures are being taken to address the systemic problem of sexual violence and harassment in schools? Specifically, has the government taken measures to provide confidential reporting protocols to protect and encourage victims who come forward and seek legal recourse?

Addressing the Needs of Vulnerable Groups

12. How does the government plan to address the grave disparity in access to reproductive and maternal health services for women in poverty, in rural areas and in the north?
13. What measures has the government taken or does the government plan to take to address the marginalization, discrimination and violence against sex workers? What efforts have been made to improve HIV/AIDS services, counseling and prevention for sex workers as the population most vulnerable to infection? What efforts have been made to reduce violence and discrimination by the police force and health care sector against sex workers, and to improve access to sexual and reproductive health care services? Has the government taken any steps to address the marginalization and discrimination against the LGBTI and disabled communities, resulting in a lack of access to services for populations already in situations of vulnerability?

Legal Framework and Implementation of Laws and Judicial Decisions

14. Does the Parliament plan to amend the HIV and AIDS Prevention and Control Bill, 2010 to address civil society concerns and bring it into compliance with international human rights standards, including the International Guidelines on HIV/AIDS and Human Rights? Will the clauses providing for compulsory testing of pregnant women and other vulnerable persons, the criminalization of HIV transmission, and the nonconsensual disclosure of HIV-status to sexual partners be removed from the bill?
15. When does the government intend to pass the Marriage and Divorce Bill? Why has it been pending for so long?
16. How does the government plan to effectively implement the recently passed Domestic Violence Act, 2010?
17. What steps has the government taken to strengthen judicial recourse for women and girls who are victims of sexual violence, and encourage them to pursue justice without fear of impunity to retaliation by their attackers? For instance, has the government initiated measures to ensure free

legal assistance, trainings for attorneys and judges to sensitize them regarding gender discrimination and sexual violence, and benchmarks to reduce the backlogging which results in most sexual violence cases being dropped?

18. How will the government ensure effective implementation of key constitutional court decisions which protect and advance women's rights?

There remains a significant gap between the provisions of the CEDAW Convention and the reality of women's reproductive and sexual health and lives in Uganda. We hope that this information is useful during the Committee's review of Uganda's compliance with the provisions of CEDAW. If you have any questions, or would like further information, please do not hesitate to contact the undersigned.

Sincerely,



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Regional Manager, Africa Program
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Maria Nassali
Executive Director
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¹ 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].

² WORLD HEALTH ORGANIZATION (WHO), MATERNAL MORTALITY IN 2000: ESTIMATES DEVELOPED BY WHO, UNICEF, UNFPA 3 (2004), available at <http://whqlibdoc.who.int/publications/2004/9241562706.pdf>. (Defining maternal mortality as "...the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.").

³ Centers for Disease Control and Prevention (CDC), Maternal and Infant Health Research: Pregnancy Complications, <http://www.cdc.gov/reproductivehealth/maternalinfanthealth/PregComplications.htm#morbidity> (accessed Jun. 15, 2010) (Defining maternal morbidity as "physical and psychological conditions resulting from or aggravated by pregnancy that have an adverse effect on the woman's health.").

⁴ Committee on the Elimination of Discrimination against Women (CEDAW Committee), *General Recommendation No. 24: Women and health (art. 12)* para. 17, UN Doc. A/54/38 (Part 1) (1999) [hereinafter CEDAW Committee, *General Recommendation No. 24*].

⁵ *Id.* para. 27.

⁶ Periodically, the United Nations Children's Fund (UNICEF), WHO and the United Nations Population Fund (UNFPA) evaluate the maternal mortality data reported by national authorities and make adjustments to account for the well-documented problems of underreporting and misclassification of maternal deaths. UNICEF & WHO, Statistics: Uganda, http://www.unicef.org/infobycountry/uganda_statistics.html#70 (accessed Aug. 11, 2010).

⁷ UGANDA BUREAU OF STATISTICS, UGANDA DEMOGRAPHIC AND HEALTH SURVEY 2006 281 (Aug. 2007) available at <http://www.measuredhs.com/pubs/pdf/FR194/FR194.pdf> [hereinafter UDHS 2006].

⁸ CEDAW Committee, *Consideration of reports submitted by States parties under Article 18 of the Convention on the Elimination of All Forms of Discrimination against Women, combined 4th, 5th, 6th and 7th reports for Uganda*, at 133, U.N. Doc. CEDAW/C/UGA/7 (May 25, 2009) [hereinafter CEDAW Committee, Uganda reports (2009)].

⁹ UNFPA, MATERNAL MORTALITY UPDATE 2002: A FOCUS ON EMERGENCY OBSTETRIC CARE 6 (2003), available at http://www.unfpa.org/upload/lib_pub_file/201_filename_mmupdate-2002.pdf (accessed Aug. 16, 2010).

¹⁰ P. P. Okong et al., *Audit of severe maternal morbidity in Uganda – implication for quality of obstetric care*, 85 ACTA OBSTET. GYNECOL. SCAND. 797-804 (2007) (This study finds that over half of patients seeking hospital care for obstetric complications experienced substandard care, while delays and other obstacles in accessing care compounded the severity of the morbidities.).

¹¹ *Id.*

¹² *Id.*

¹³ REPUBLIC OF UGANDA, MINISTRY OF HEALTH, NATIONAL HEALTH POLICY 1999 para. 2.4 (1999).

¹⁴ The HC-II level health facilities provide only ambulatory services, except in strategic locations where there is poor access to referral facilities and maternity services are being provided as an interim strategy. The HC-III offers continuous basic preventive, promotive, and curative care and provides support supervision of the community and HC-IIs under its jurisdiction. There are provisions for laboratory services for diagnosis, maternity care, and first referral coverage for the sub-county. REPUBLIC OF UGANDA, MINISTRY OF HEALTH, UGANDA SERVICE PROVISION ASSESSMENT SURVEY 2007 17-18 (2008), *available at* http://pdf.usaid.gov/pdf_docs/PNADM577.pdf [hereinafter 2007 USPAS].

¹⁵ REPUBLIC OF UGANDA, MINISTRY OF HEALTH, UGANDA HEALTH SECTOR STRATEGIC PLAN III 2010/2011 TO 2014/2015 85 (2010) [hereinafter UGANDA HEALTH SECTOR STRATEGIC PLAN]; *see also* UGANDA HEALTH SECTOR STRATEGIC PLAN, at 41-42 (one of the Plan's strategic actions for promoting gender equality is to improve the quality and availability of maternal and reproductive healthcare for women and girls by targeting women in HIV services.); UGANDA HEALTH SECTOR STRATEGIC PLAN, at 80 (in addition, the 1999 National Health Policy commits to ensuring access to a "Minimum Health Care Package" which includes essential antenatal and obstetric care, family planning, adolescent reproductive health, and programs that address violence against women).

¹⁶ Press Release, WHO, Uganda's First Lady Launches Road Map to Accelerate Reduction of Maternal and Neonatal Mortality and Morbidity (Nov. 24, 2008), *available at* <http://www.afro.who.int/en/uganda/press-materials/1444-ugandas-first-lady-launches-road-map-to-accelerate-reduction-of-maternal-and-neonatal-mortality-and-morbidity.html>.

¹⁷ CEDAW Committee, Uganda reports (2009), *supra* note 8, at 139.

¹⁸ HON. DR. STEPHEN MALLINGA, MP, MINISTRY OF HEALTH, HEALTH SECTOR MINISTERIAL POLICY STATEMENT FINANCIAL YEAR 2009/2010 (Jun. 2009), *available at* http://www.ugandacusters.ug/dwnlds/0204Karamoja/KARA29-8-09/Ministerial_Policy_for_the_Health_Sector.pdf; *see also* Frederick Womakuyu, *Uganda: What do women stand to gain?*, *The New Vision*, Jun. 21, 2010, *available at* <http://allafrica.com/stories/printable/201006220202.html> (accessed Aug. 6, 2010).

¹⁹ REPUBLIC OF UGANDA, MINISTRY OF HEALTH, HEALTH SECTOR BUDGET FRAMEWORK 2010/2011 24, 27 (2009), *available at* http://www.finance.go.ug/docs/Health_Merged_N.pdf (accessed Aug. 9, 2010) [hereinafter HEALTH SECTOR BUDGET FRAMEWORK].

²⁰ *Id.*

²¹ SIBYLLE KOENIG & BELINDA ATIM, GERMAN FOUNDATION FOR WORLD POPULATION (DSW) AND ACTION FOR GLOBAL HEALTH, HEALTH SPENDING IN UGANDA: THE IMPACT OF CURRENT AID STRUCTURES AND AID EFFECTIVENESS 6 (2010) [hereinafter HEALTH SPENDING IN UGANDA].

²² *Id.* at 10.

²³ MALLINGA, *supra* note 18, at 13.

²⁴ HEALTH SECTOR BUDGET FRAMEWORK, *supra* note 19, at 47.

²⁵ *See, e.g.*, CEDAW Committee, *Concluding Observations: Burkina Faso*, para. 349, U.N. Doc. A/60/38 (2005); *Georgia*, para. 29, U.N. Doc. CEDAW/C/GEO/CO/3(2006); *Namibia*, para. 24, U.N. Doc. CEDAW/C/NAM/CO/3 (2007).

²⁶ *See, e.g.*, CEDAW Committee, *Concluding Observations: Chile*, para. 156 U.N. Doc. A/50/38, (1995); *Cyprus*, para. 64, U.N. Doc. A/51/38 (1996); *Czech Republic*, para. 102, U.N. Doc. A/57/38 (2002); *Iceland*, para. 88, U.N. Doc. A/51/38 (1996); *Lithuania*, para. 161, U.N. Doc. A/55/38(2000); *Luxembourg*, paras. 203, 209, 222, U.N. Doc. A/52/38/Rev.1, Part II (1997); *Maldives*, para. 143, U.N. Doc. A/56/38 (2001); *Nepal*, para. 213, U.N. Doc. CEDAW/C/NPL/CO/3 (2004); *Turkey*, para. 205, U.N. Doc. A/52/38/Rev.1 (1997).

²⁷ Facilities that provide antenatal care (ANC) do not regularly monitor care provision, with only 12 percent documenting ANC coverage. 2007 USPAS, *supra* note 14, at 118. Only 5% of facilities have a registry for monitoring post partum care. 2007 USPAS, *supra* note 14, at 118.

²⁸ 2007 USPAS, *supra* note 14, at 108.

²⁹ UDHS 2006, *supra* note 7, at 119, 121.

³⁰ *Id.* at 121.

³¹ *Id.* at 119-123.

³² 2007 USPAS, *supra* note 14, at 114. (These include including folic acid and iron supplements, blood pressure machines foetoscopes and TT vaccines.)

³³ *Id.* at 115. (These include anemia, pre-eclampsia and eclampsia, and STIs.)

³⁴ CEDAW, *supra* note 1, art. 12, para. 2.

³⁵ 2007 USPAS, *supra* note 14, at 26, 124.

³⁶ UDHS 2006, *supra* note 7, at 125.

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⁶⁵ While the vast majority of women surveyed by the UDHS 2006 had heard about family planning on television, video, film, radio or in a newspaper or magazine, women living in rural areas and women who have no education were less likely to be

exposed to family planning messages, and only four percent of women who were not users of family planning and were targeted by family planning outreach programs were reached by field workers to discuss family planning. Furthermore, “only 12 % of nonusers visited a health facility and were spoken to about family planning. Altogether, 86 % of nonusers were not contacted about family planning through either of these two mechanisms in the 12 months preceding the survey. UDHS 2006, *supra* note 7, at 80-81.

⁶⁶ According to the 2007 USPAS, only nine percent of facilities that provide intra-uterine devices (IUD) as a method of contraception had all the associated equipment available for removal and insertion, and satisfied the USPAS criteria, which include “all infection control items, visual privacy, an examination bed/table, an examination light, and the method.” 2007 USPAS, *supra* note 14, at 97.

⁶⁷ Dradenya Amazia, *Uganda: Moyo Lacks Contraceptives*, The New Vision, May 27, 2010, available at <http://allafrica.com/stories/201005280375.html> (accessed Jun. 9, 2010); See also Frederick Womakuyu, *Uganda: No Contraceptives for Bududa IDPs*, The New Vision, Apr. 14 2010, available at <http://allafrica.com/stories/printable/201004150202.html> (accessed Jun. 14, 2010); Joel Ogwang, *Uganda: Condom Shortage Worries Health Experts*, The New Vision, Jun. 13 2010, available at <http://allafrica.com/stories/printable/201006141094.html> (accessed Jun. 15, 2010).

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⁷³ INTERNATIONAL CONSORTIUM FOR EMERGENCY CONTRACEPTION, PATH TOOLKIT: RESOURCES FOR EMERGENCY CONTRACEPTIVE PILL PLANNING, MODULE B: COST CONSIDERATIONS B4-B5 (2004), available at http://www.cecinfo.org/publications/PDFs/resources/Toolkit_ModuleB_CostConsiderations.pdf (accessed Aug. 11, 2010).

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¹²⁹ REPUBLIC OF UGANDA CONST. art. 22(2) (1995); PENAL CODE ACT CH. XIV S. 141-143, *supra* note 128.

¹³⁰ *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, 34 (2010).

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¹³⁶ HEALTH SPENDING IN UGANDA, *supra* note 21, at 10.

¹³⁷ UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA, *supra* note 125, at 11.

¹³⁸ ABORTION AND POSTABORTION CARE IN UGANDA, *supra* note 62, at 28.

¹³⁹ *Id.* at 5.

¹⁴⁰ Els De Temmerman & Irene Nabusoba, *Abortion Kills 1,200 Women Every Year*, New Vision Sept. 14, 2007, available at <http://www.newvision.co.ug/PA/9/183/586728>.

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¹⁴³ USPAS, *supra* note 14, at 132.

¹⁴⁴ *Id.* at 136, tbl 6.13.

¹⁴⁵ ABORTION AND POSTABORTION CARE IN UGANDA, *supra* note 62, at 17.

¹⁴⁶ *Id.* at 6.

¹⁴⁷ *Id.* at 7.

¹⁴⁸ Temmerman, *supra* note 140.

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- ¹⁶³ European AIDS Treatment Group, Ugandan Parliament Considers Bill That Would Require HIV Status Disclosure, Provide some Protections to HIV-Positive People (2008), available at <http://www.eatg.org/eatg/Global-HIV-News/World-Policy/Ugandan-parliament-considers-bill-that-would-require-HIV-status-disclosure-provide-some-protections-to-HIV-positive-people> (accessed Aug. 11, 2010).
- ¹⁶⁴ AVERT, *supra* note 154.
- ¹⁶⁵ *THE HIV/AIDS EPIDEMIOLOGICAL SURVEILLANCE REPORT 2005-2007*, *supra* note 161, at 34, 57.
- ¹⁶⁶ For instance, the proportion of sexually active Ugandans who reported having had two or more sexual partners in the previous 12 months increased from two to four % between 2000-01 and 2004-05 among women and from 25 to 29 % among men. *Id.* at 36.
- ¹⁶⁷ *Id.*
- ¹⁶⁸ *Id.* at 56-57.
- ¹⁶⁹ *HIV/AIDS, HUMAN RIGHTS, AND LEGAL SERVICES IN UGANDA*, *supra* note 154, at vii, 24.
- ¹⁷⁰ HUMAN RIGHTS WATCH, JUST DIE QUIETLY: DOMESTIC VIOLENCE AND WOMEN'S VULNERABILITY TO HIV IN UGANDA 30 (2003), available at <http://www.hrw.org/reports/2003/uganda0803/>.
- ¹⁷¹ SWIZEN KYOMUHENDO & JOSEPH KIWANUKA, ACCESS TO CARE, TREATMENT AND SEXUAL AND REPRODUCTIVE HEALTH RIGHTS NEEDS OF HIV POSITIVE WOMEN IN MASINDI AND BUSIA DISTRICTS v. (2007).
- ¹⁷² Sylvia Rowley, *HIV and women's rights in Uganda: why a new law would hurt women* (Jan. 3, 2009), available at <http://www.opendemocracy.net/blog/email/sylvia-rowley/2009/03/01/hiv-and-womens-rights-in-uganda-why-a-new-law-would-hurt-women>.
- ¹⁷³ DRAFT BILL No. 5, HIV AND AIDS PREVENTION AND CONTROL BILL, 2010, Bills Supp. TO THE UGANDA GAZETTE No. 24 VOL. CIII (2010) [hereinafter *HIV & AIDS PREVENTION & CONTROL BILL*].
- ¹⁷⁴ Shelia Naturinda, *Bill to force spouses to reveal HIV status*, Kampala News (Dec. 12, 2008), available at: <http://www.monitor.co.ug/artman/publish>.
- ¹⁷⁵ *HIV AND AIDS PREVENTION AND CONTROL BILL*, *supra* note 175, Cl. 14, 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) [hereinafter *HRW COMMENTS ON HIV/AIDS BILL*].
- ¹⁷⁶ *HIV & AIDS PREVENTION & CONTROL BILL*, *supra* note 175, Cl. 13(c).
- ¹⁷⁷ See e.g. HRW COMMENTS ON HIV/AIDS BILL, *supra* note 177.
- ¹⁷⁸ 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, 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-intenguidelines_en.pdf.
- ¹⁷⁹ *Id.* para. 96.
- ¹⁸⁰ 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).
- ¹⁸¹ HRW COMMENTS ON HIV/AIDS BILL, *supra* note 177, para. 1.
- ¹⁸² *HIV & AIDS PREVENTION & CONTROL BILL*, *supra* note 175, Cl. 23.
- ¹⁸³ *Id.* See also Anthony Bugembe, *AIDS Activists Reject Bill*, The New Vision, Oct. 28, 2008, available at: <http://www.aegis.com/news/nv/2008/NV081020.html>.
- ¹⁸⁴ Global Health Reporting.org, *Ugandan Parliament Considers Bill that Would Require HIV Status Disclosure, Provide Some Protections to HIV-Positive People* (2008), www.globalhealthreporting.org/article.asp?DR_ID=56071.
- ¹⁸⁵ DRAFT HIV & AIDS PREVENTION & CONTROL BILL, *supra* note 175, Cl. 41. (“(1) A person who willfully and intentionally transmits HIV to another person commits an offence , and on conviction shall be liable to a fine of not more than two hundred

and forty currency points or to imprisonment for a term of not more than ten years or both. (2) A person shall not be convicted of an offence under subsection (1) if – (a) the person was aware of the HIV status of the accused and the risk of infection and he or she voluntarily accepted the risk; (b) the alleged transmission was through sexual intercourse and protective measures were used during penetration.”

¹⁸⁶ See CEDAW Committee, *Concluding Observations: Belize*, para.39, U.N. Doc. A/54/38 (1999).

¹⁸⁷ *Id.*

¹⁸⁸ See, e.g., CEDAW Committee, *Concluding Observations: Belize*, para. 58, U.N. Doc. A/54/38 (1999); *Burundi*, para. 59, U.N. Doc. A/56/38 (2001); *Estonia*, para. 111, U.N. Doc. 1/57/38 (2002); *Fiji*, para. 62, U.N. Doc. A/57/38(2002); *Ghana*, para. 31, U.N. Doc. CEDAW/C/GHA/CO/5 (2006); *Guinea*, para. 130, U.N. Doc. A/56/38 (2001); *Guyana*, paras. 151, 178, U.N. Doc. A/56/38 (2001); *Malawi*, para. 31, U.N.Doc. CEDAW/C/MWI/CO/5 (2006); *Myanmar*, para. 121, U.N.Doc. A/55/38 (2000); *Namibia*, para. 79, U.N. Doc.A/52/38/Rev.1, Part II (1997); *Romania*, para. 314, U.N. Doc.A/55/38 (2000); *Togo*, para. 28, U.N. Doc.CEDAW/C/TGO/CO/5 (2006); *United Kingdom of Great Britain and Northern Ireland*, para. 309, U.N. Doc. A/54/38(1999); *Viet Nam*, para. 266, U.N. Doc. A/56/38 (2001).

¹⁸⁹ See CEDAW Committee, *Concluding Observations: Antigua and Barbuda*, para. 261, U.N. Doc.A/52/38/Rev.1, Part II (1997).

¹⁹⁰ CEDAW Committee, *Concluding Observations: Uganda*, para. 313,03/02/1995, U.N. Doc. A/50/38 (1995);

¹⁹¹ UGANDA HIV/AIDS SERO-BEHAVIORAL SURVEY, *supra* note 96, at 117, 125.

¹⁹² *Id.* at 125.

¹⁹³ Irene Nabusoba, *Uganda: Cervical Cancer – Just Because She Did Not Check in Time*, The New Vision (2010), <http://allafrica.com/stories/printable/201003081030.html>.

¹⁹⁴ Rengaswamy Sankaranarayan et al., *Cancer survival in Africa, Asia, and Central America: a population-based study*, 11 LANCET ONCOL 165, 168 (Dec. 2010).

¹⁹⁵ H Wabinga et al., *Survival of cervix cancer patients in Kampala, Uganda: 1995-1997*, 89 BRITISH J OF CANCER 65, 68 (2003).

¹⁹⁶ Sankaranarayan, *supra* note 196, at 11.

¹⁹⁷ FX Bosch et al, *Prevalence of human papillomavirus in cervical cancer: a worldwide perspective*, International Biological Study on Cervical Cancer Study Group, 87 J NATL CANCER 796-802 (1995).

¹⁹⁸ CEDAW, *supra* note 1, art. 1 (emphasis added).

¹⁹⁹ CEDAW Committee, *General Recommendation No. 19: Violence against women*, (11th Sess., 1992), para. 6, U.N. Doc. A/47/38 (1993) [hereinafter *CEDAW Committee, General Recommendation No. 19*].

²⁰⁰ CEDAW, *supra* note 1, at art. 2(d)-(e) (“States Parties ... undertake ... [t]o refrain from engaging in any act or practice of discrimination against women and to ensure that public authorities and institutions shall act in conformity with this obligation [and to] take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise.”).

²⁰¹ *CEDAW Committee, General Recommendation No. 19, supra* note 199, paras. 4, 6.

²⁰² 2007 USPAS, *supra* note 14, at 213, Appx. A.

²⁰³ UDHS 2006, *supra* note 7, at 133.

²⁰⁴ *See* 2007 USPAS, *supra* note 14, at 99.

²⁰⁵ HEALTH SPENDING IN UGANDA, *supra* note 21, at 17.

²⁰⁶ 2007 USPAS, *supra* note 14, at 118; *see also* 2007 USPAS, at 281 Appx A-6.11.

²⁰⁷ HEALTH SPENDING IN UGANDA, *supra* note 21, at 17.

²⁰⁸ 2007 USPAS, *supra* note 14, at 99; *see also* 2007 USPAS at 264 Appx A-5.15.

²⁰⁹ UDHS 2006, *supra* note 7, at 76.

²¹⁰ *Id.* at 74. 43% of all users of modern contraceptive methods, of which implants are the most popular, obtain their supply at private health facilities.

²¹¹ INTERNATIONAL PLANNED PARENTHOOD FEDERATION (IPPF), *CONTRACEPTION AT A CROSSROADS* 75 (2008). (The proportion of family planning provided by private facilities has increased continuously since 1995, thus the user fees charged by these private facilities have imposed a barrier to access on an increasing number of women in need of family planning services.) *See also* The average cost of contraception ranges from 115 Uganda shillings (\$0.05 USD) for a package of male condoms to almost 20,000 shillings (\$9 USD) for female sterilization. The median cost for a packet of pills is 277 shillings (\$0.12 USD) and for a contraceptive injection, 964 shillings (\$0.45 USD). UDHS 2006, *supra* note 7, at 76.

²¹² The World Bank, *Uganda Data Profile*, (2010), available at http://ddp-ext.worldbank.org/ext/ddpreports/ViewSharedReport?REPORT_ID=9147&REQUEST_TYPE=VIEWADVANCED&DIMENSIONS=213 (accessed Jun. 14, 2010).

²¹³ UNITED NATIONS DEVELOPMENT PROGRAMME, *HUMAN AND INCOME POVERTY: DEVELOPING COUNTRIES / POPULATION LIVING BELOW \$2 A DAY (%)*, HUMAN DEVELOPMENT REPORT (2009), available at <http://hdrstats.undp.org/en/indicators/103.html>.

²¹⁴ WOMEN’S COMMISSION FOR REFUGEE WOMEN AND CHILDREN & UNFPA, *WE WANT BIRTH CONTROL*, *supra* note 42, at 5.

²¹⁵ UDHS 2006, *supra* note 7, at 133-134; tbl. 10.12.

²¹⁶ WOMEN’S COMMISSION FOR REFUGEE WOMEN AND CHILDREN & UNFPA, *WE WANT BIRTH CONTROL*, *supra* note 42, at 16.

²¹⁷ THE HIV/AIDS EPIDEMIOLOGICAL SURVEILLANCE REPORT, *supra* note 161, at 25.

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- ²¹⁸ African Press, *Uganda: Sex workers want to be included in the national HIV dialogue*, (2010), available at <http://africanpress.wordpress.com/2010/07/13/uganda-sex-workers-want-to-be-included-in-the-national-hiv-dialogue/>.
- ²¹⁹ HEALTH SPENDING IN UGANDA, *supra* note 21, at 10.
- ²²⁰ MADSEN, *supra* note 50, at 14.
- ²²¹ *Id.*
- ²²² CEDAW Committee, *Concluding Observations: Uganda*, para.135, U.N. Doc. A/57/38 (2002).
- ²²³ *Id.*, para. 133.
- ²²⁴ UDHS 2006, *supra* note 7, at 294.
- ²²⁵ UGANDA POLICE, CRIME REPORT 2009 para. 8, at 4 (2009) [hereinafter CRIME REPORT 2009].
- ²²⁶ UDHS 2006, *supra* note 7, at 286, xxvii.
- ²²⁷ *Id.* at 286.
- ²²⁸ *Id.* at 250.
- ²²⁹ *Id.* at 289.
- ²³⁰ *Id.* at 291.
- ²³¹ *Id.* at 292.
- ²³² AMNESTY INTERNATIONAL, "I CAN'T AFFORD JUSTICE": VIOLENCE AGAINST WOMEN IN UGANDA CONTINUES UNCHECKED AND UNPUNISHED 18 (2010), available at <http://www.amnesty.org/en/library/asset/AFR59/001/2010/en/f3688aa0-b771-464b-aa88-850bcbf5a152/af590012010en.pdf>.
- ²³³ Joyce Mulama, *Developing Stronger Protection Against Gender-Based Violence*, Inter Press Service News Agency (Apr. 18, 2009), available at <http://www.ipsnews.net/news.asp?idnews=46550>.
- ²³⁴ WOMEN'S COMMISSION FOR REFUGEE WOMEN AND CHILDREN & UNFPA, WE WANT BIRTH CONTROL, *supra* note 42, at 8.
- ²³⁵ Mulama, *supra* note 235.
- ²³⁶ WOMEN'S COMMISSION FOR REFUGEE WOMEN AND CHILDREN & UNFPA, WE WANT BIRTH CONTROL, *supra* note 42, at 5.
- ²³⁷ CRIME REPORT 2009, *supra* note 227, para. 27-28, at 22. Nationwide, in 2009, only 12 of the reported rapes was fully prosecuted and perpetrators convicted, and of the 4,433 defilement cases that were reported only 467 resulted in convictions.
- ²³⁸ AFRICA FOR WOMEN'S RIGHTS, RATIFY AND RESPECT: UGANDA, 4 (2002), available at http://www.africa4womensrights.org/public/Dossier_of_Claims/Uganda-UK.pdf (Accessed Jun. 14, 2010); *see also* AMNESTY INTERNATIONAL, *supra* note 111.
- ²³⁹ FIDA-Uganda, Complaint against the Red Pepper Newspaper, Media Council, Uganda (November 13, 2009) (on file at the Center for Reproductive Rights).
- ²⁴⁰ CEDAW Committee, *General Recommendation No. 21: Equality in marriage and family relations* (13th Sess., 1994), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.1 at 90 (1994) [hereinafter CEDAW Committee, *General Recommendation No. 21*].
- ²⁴¹ *Id.* paras. 14-16.
- ²⁴² CEDAW Committee, *General Recommendation No. 19*, *supra* note 201, para. 11.
- ²⁴³ Social Institutions and Gender Index, Gender Equality and Social Institutions in Uganda, available at <http://genderindex.org/country/uganda> (accessed Jun. 10, 2010).
- ²⁴⁴ UDHS 2006, *supra* note 7, at 246.
- ²⁴⁵ VANESSA VON STRUENSEE, THE DOMESTIC RELATIONS BILL IN UGANDA: POTENTIAL FOR ADDRESSING POLYGAMY, BRIDE PRICE, COHABITATION, MARITAL RAPE, WIDOW INHERITANCE, AND FEMALE GENITAL MUTILATION 2-3 (2008).
- ²⁴⁶ *Id.* at 1.
- ²⁴⁷ CEDAW Committee, *General Recommendation No. 21*, *supra* note 240, para. 36.
- ²⁴⁸ *Id.*
- ²⁴⁹ UDHS 2006, *supra* note 7, at 88.
- ²⁵⁰ Murk, *supra* note 55, at 82.
- ²⁵¹ ADOLESCENT SEXUAL & REPROD. HLTH. IN UGANDA, *supra* note 93, at 15.
- ²⁵² *Id.* at 14.
- ²⁵³ Jeannie Annan et al., *The state of female youth in northern Uganda: findings from the survey of war-affected youth (SWAY) Phase II*, (April 2008), available at <http://www.crin.org/docs/Survey%20of%20War%20Affected%20Youth%20II.pdf> (accessed Aug. 10, 2010).
- ²⁵⁴ *Id.* at 39.
- ²⁵⁵ *Id.* at vii, 43.
- ²⁵⁶ Jennifer Schmidt, *Sexual and Reproductive Health Challenges in Post-Conflict Northern Uganda*, 2 POLIS JOURNAL 26 (Winter 2009), available at <http://www.polis.leeds.ac.uk/assets/files/students/student-journal/ma-winter-09/jennifer-schmidt-winter-09.pdf> (accessed August 11, 2010).
- ²⁵⁷ Annan, *supra* note 253, at vi.
- ²⁵⁸ *Id.* at 61.
- ²⁵⁹ CEDAW Committee, *General Recommendation No. 19*, *supra* note 199, para. 20.

²⁶⁰ General Recommendation No. 19 affirms that: “States may also be responsible for private acts if they fail to act with due diligence to prevent violations of rights or to investigate and punish acts of violence, and for providing compensation.” CEDAW Committee, *General Recommendation No. 19*, *supra* note 201, para. 9.

²⁶¹ CEDAW Committee, *Concluding Observations: Uganda*, para. 333, U.N. Doc. A/50/38 (1995).

²⁶² Emmanuel Monjok et al., *Female Genital Mutilation: Potential for HIV Transmission in Sub-Saharan African and Prospect for Epidemiological Investigation and Intervention*, 11 AFR. J OF REPRO HLTH. No. 1 33-42 (published by the Women’s Health and Action Research Center) (2007).

²⁶³ The Anti Female Genital Mutilation Act 2010; IPPF, *African MPs push for continent-wide FGM ban* (2010), available at <http://www.ippf.org/en/News/Intl+news/African+MPs+push+for+continent+wide+FGM+ban.htm> (accessed Jun. 9, 2010); see also BBC World News, *Uganda bans female genital mutilation*, <http://news.bbc.co.uk/2/hi/africa/8406940.stm> (accessed Jun. 10, 2010).

²⁶⁴ See Lydia Mukisa, *Female genital mutilation illegal, court rules*, THE MONITOR (Jul. 30, 2010) available at <http://www.monitor.co.ug/News/National/-/688334/967406/-/view/printVersion/-/g1hywoz/-/index.html> (accessed Aug. 9, 2010).

²⁶⁵ David Mafabi, *Uganda: When Culture Confronts Health and the Law*, THE MONITOR (Jul. 10, 2010), available at <http://allafrica.com/stories/printable/201007120398.html> (accessed Aug. 9, 2010); see also It may continue to occur, particularly in the Eastern region and the Karamoja sub-region. UDHS 2006, *supra* note 7, at 135; FGM may also remain a common practice within the Sabiny Tribe in the Kapchorwa district in the East and the Pokot ethnic group along the northeastern border. AFRICA FOR WOMEN’S RIGHTS, RATIFY AND RESPECT: UGANDA, *supra* note 240.

²⁶⁶ Mafabi, *supra* note 265.