CESCR Secretariat
8-14 Avenue de la Paix
CH 1211 Geneva 10
Switzerland

April 24, 2015

Re: Supplementary Information on Uganda, Scheduled for Review by the Committee on Economic, Social, and Cultural Rights during its 55th Session

Distinguished Committee Members:

This letter is intended to supplement the initial periodic report submitted by the Government of Uganda, which is scheduled to be reviewed during the 55th Session of the Committee on Economic, Social, and Cultural Rights (the Committee). The Center for Reproductive Rights (the Center), a global legal advocacy organization with headquarters in New York and regional offices in Nairobi, Bogotá, Kathmandu, Geneva, and Washington D.C. hopes to further the work of the Committee by providing independent information concerning the rights protected under the International Covenant on Economic, Social, and Cultural Rights (CESCR),[1] as well as other international and regional human rights instruments that Uganda has ratified.[2]

This letter highlights the following concerning issues that violate the rights of women and girls protected under the CESCR: (1) lack of access to comprehensive family planning services and information, (2) lack of access to safe, legal abortion services and post-abortion care, (3) the high rates of preventable maternal mortality and morbidity, (4) adolescents' lack of access to reproductive health care information, including sexuality education and services, and (5) discrimination against women and girls including discrimination against women living with HIV and AIDS and physical and sexual violence. This letter includes information regarding unsafe abortion and lack of access to family planning information and services that is drawn from the Center's fact-finding report, *The Stakes Are High: The Tragic Impact of Unsafe Abortion and Inadequate Access to Contraception in Uganda* (*The Stakes Are High*),[3] which has been submitted with this letter.

Morningside Office Park
1st Floor, Wing A
Ngong Road
P.O Box 48136-00100
Nairobi, Kenya
Tel. +254 20 251 8361
www.reproductiverights.org

I. The Right to Equality and Non-Discrimination

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

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

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

II. The Right to Reproductive Health Care

The right of women and girls to access comprehensive reproductive health services receives broad protection under all the major international and regional human rights instruments, including the CESCR, which, under Article 12, recognizes "the right of everyone to the enjoyment of the highest standard of physical and mental health."[19] The Committee, in General Comment 14, has clarified that the right to health includes "the right to control one's health and body, including sexual and reproductive freedom,"[20] which "requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health."[21] In order to comply with this obligation, therefore, states are required to take "measures to improve child and maternal health, sexual and reproductive health services, including access to family planning … emergency obstetrics services and access to information, as well as to resources necessary to act on that information." [22] In the absence of these services, women and girls may experience unwanted and unsafe pregnancies and deliveries, possibly exposing them to life-threatening complications.

A. Lack of Access to Comprehensive Family Planning Information and Services (Articles 2 (2), 3, 12)

The Committee has consistently recognized that the lack of access to family planning information and services violates the right to health,[23] and that low rate of contraceptive use contributes to unsafe abortions and maternal deaths.[24] The availability requirement of the right to health under CESCR imposes an obligation on states to provide all essential drugs on the World Health Organization (WHO) List of Essential Medicines, including the full range of contraceptives.[25] This Committee has emphasized the high priority of physical and economic access to reproductive health care services, and it specifically called on state parties to "adequately fund[] the free distribution of contraceptives"[26] and to "include the costs of modern contraceptive methods in the public health insurance scheme."[27] In addition, the Committee on the Elimination of Discrimination against Women (CEDAW Committee) has called on Uganda to "strengthen and expand efforts to increase knowledge of and access to affordable contraceptive methods" and "ensure that women in rural areas do not face barriers in accessing family planning information and services."[28]

Lack of Access to Family Planning Information and Services

In the List of Issues (LOIs), the Committee asked the Government of Uganda to **"indicate the steps taken to enhance access to sexual and reproductive health services and information, including access to contraceptives … while indicating any existing disparity in such access, including on grounds of socioeconomic situation, geographical location, age or marital status."**[29] The government, in its report to the Committee, stated that it has improved the management of family planning commodities which has resulted in increased access to family planning services.[30] While the unmet need for contraceptives has decreased from 41% in 2006[31] to 34% in 2011,[32] and while the use of modern contraception increased from 15% in 2007[33] to 26% in 2011,[34] a vast number of women and girls still do not have access to contraceptive information and services. According to the 2011 Uganda Demographic Health Survey (UDHS 2011) three quarters of Ugandan women still do not use modern contraception,[35] and 42% of pregnancies in Uganda are unintended.[36] There are also disparities in usage of contraceptives depending on women's level of education, their geographical location, and income level. For instance, 44% of married women with a secondary or higher level of education are using a contraceptive method compared to only 18% of the married women with no education.[37] Further, the contraceptive use rate for women in urban areas is 46% compared to 27% in rural areas; 48% of married women in Kampala—the capital city—compared to only 8% in Karamoja—a region located in the North Eastern part of Uganda characterized by chronic poverty and lack of resources;[38] and 46% of women in the highest wealth quintile compared to 15% in the lowest wealth quintile.[39]

This low contraceptive use and high unmet need can be attributed to the numerous barriers women and girls encounter in trying to access family planning services, including user fees, unavailability of preferred contraceptive method,[40] improper counseling services,[41] lack of information about contraceptives, and absence of necessary supplies to insert certain methods.[42] Other factors, such as the fear of side effects[43] inconvenience of using modern contraceptives, partners' opposition to contraceptive use, and the belief that contraceptives are prohibited by religion, inhibit women from using contraceptives.[44]

The Center's 2013 fact-finding report, *The Stakes Are High*, made similar findings and documented the impact of the denial of the right to family planning services on women's lives. In one instance, Nansubuga, a woman who lives in Kampala, explained that she decided to discontinue the use of contraceptives because she believed that she would become infertile after using a family planning method for a long time.[45] However, immediately after she stopped using an oral contraceptive, she conceived and ultimately

underwent a clandestine abortion.[46] Joyce, another woman interviewed for the study, shared that her husband beat her because of his misconception about contraceptives. Joyce explained, "[my husband] didn't want me to take the pills because [he said] they destroy a woman's reproductive health. [He said they] also destroy their sexual urge. That's what he told me and he gave me a thorough beating. He beat me very badly; all of my body was swollen."[47]

Other women reported feeling hesitant to obtain contraceptives because using or even discussing contraceptives with their spouses or male partners could imply infidelity.[48] As one interviewee in *The Stakes Are High* noted, "women exercising control over their own reproductive choices are often suspected of being unfaithful to their husbands or engaging in other illicit activities."[49] In addition, lack of information about the different contraceptive methods and where to access contraceptives is a significant barrier to access. One study found that 13% of women surveyed indicated that they did not know where they could obtain contraceptives or they could not access a health center that offers contraceptives.[50] In the Center's report, a sex worker named Edith described experiencing multiple unplanned and unwanted pregnancies and unsafe abortions because she lacked information about contraceptive methods and services.[51] She noted that her life improved greatly once she had access to family planning services.[52]

Inequality and discrimination against women are also major barriers to contraceptive use and may result in, for example, women's lack of autonomy to decide when to have children or providers' negative attitude towards unmarried women and girls who seek contraceptive services. The power imbalance between men and women often makes it difficult for women to negotiate contraceptive use with their partners, especially male-controlled methods such as condoms.[53] As reported in *The Stakes Are High*, a volunteer in one local clinic in Kampala explained:

> It's difficult to tell a man to wear a condom, especially if that man is your husband. When he refuses, there's no way [you can] force him to wear it. How can a man buy for you food when you have denied to give him sex? It is very difficult to deny your husband sex, because he is entitled, and if you refuse, he has a right to ask you to leave the home.[54]

Women also face the personal bias of health care providers, resulting in discrimination in health care facilities. For example, third-party or spousal consent is often imposed as a condition to access family planning services, even though this is not required under Uganda's laws and policies.[55] This practice not only denies reproductive autonomy to all women, but it also is particularly discriminatory towards unmarried women and adolescents who are not able to produce such consent.

Although the government allocated USD 6.9 million of the 2014-2015 budget to reproductive health commodities, there was a USD 2.4 million funding gap.[56] The government has not increased this budget for the 2015-2016 fiscal year,[57] indicating that there is still a large gap in funding.

Lack of Access to Emergency Contraception (EC)

The right to enjoy the benefits of scientific progress, which is guaranteed in the CESCR,[58] should include family planning services, specifically all forms of modern contraceptives. In Uganda, emergency contraception (EC), a critical component of care for survivors of sexual violence and a means to reduce the number of unintended pregnancy and unsafe abortions,[59] is registered and included in the Essential Medicines and Health Supplies List.[60] However, use and awareness of the method remains low.[61] The 2007 Uganda Service Provision Assessment Survey shows that the number of women who have ever used EC in

Uganda is close to zero, while just 18% of health facilities that offer any family planning services reported supplying EC.[62] The 2011 UDHS reported that only 31% of women know about EC.[63]

The low knowledge and usage of EC can be attributed to a number of factors. Due to insufficient training, health care workers lack knowledge about the proper uses of the EC, as well as how to counsel patients on using the method as a form of contraception.[64] As a result of this lack of accurate information, they also display bias that restricts its use and acceptance.[65] Common misperceptions about EC, such as the notion that it will inhibit future fertility, cause extreme side effects,[66] and encourage sexual promiscuity,[67] are also barriers to use. However, these perceptions are unfounded: as the World Health Organization (WHO) has noted, side-effects of EC are uncommon and generally mild and do not affect fertility.[68]

B. Prevalence of Unsafe Abortion and Lack of Post-Abortion Care (Articles 2 (2), 3, 12)

Unsafe abortion is one of the most preventable causes of maternal mortality and morbidity; complications arising from unsafe abortion expose women to serious risks, including death and long-term disabilities.[69] The Committee has called on states to remove barriers to safe, legal abortion services, including the high cost of abortion services[70] and the lack of information on sexual and reproductive health services.[71] The CEDAW Committee has articulated its concern that unsafe abortions are a major factor causing Uganda's high maternal mortality rates,[72] including with respect to maternal deaths of adolescent girls,[73] and it has recommended that the Uganda implement national reproductive health programs to prevent unsafe abortions.[74]

High Incidence of Unsafe Abortion

In the **LOIs**, the Committee asked the Government of Uganda to **"clarify on what grounds abortion is permitted in the State party … [and] clarify existing inconsistencies between the Penal Code and the National Guidelines and Services Standards for Sexual and Reproductive Health and Rights concerning the grounds for permitting abortion."**[75] This is due to the ambiguity and misinformation surrounding the laws on abortion in Uganda which continues to significantly contribute to the prevalence of unsafe abortions and, in turn, maternal mortality and morbidity. Under both the Constitution and the Penal Code, abortion is allowed only when the woman's life is in danger.[76] Pre-independence jurisprudence on abortion, which remains applicable in Uganda, clarifies that the life exception in the Penal Code encompasses exceptions for risks to a women's physical and mental health.[77] Further, the Health Ministry's Uganda National Guidelines and Services Standards for Sexual and Reproductive Health and Rights (Reproductive Health Guidelines) provides expanded grounds for permitting legal abortion—such as sexual violence and incest—and outlines comprehensive abortion and post-abortion care standards.[78] However, narrow interpretations of abortion laws by the courts and other government bodies, as well as extremely restricted access to relevant information, have resulted in misinformation about the legality of abortion among the general public, health care providers, law enforcement, the judiciary, and regulators.[79] This misinformation is also demonstrated in the government's report to the Committee where the government states that "abortion is illegal in Uganda"[80] without clarifying that there are instances when abortion is permitted.

As a result, as documented in *The Stakes Are High*, most doctors and other trained providers mistakenly believe that there is a complete prohibition on abortion. Due to this, they are reluctant to provide the comprehensive services outlined in the Reproductive Health Guidelines for fear of being subjected to criminal liability under the Penal Code.[81] Dr. Andrew, an interviewee in the report, who has practiced gynecology for twenty years, stated that he was told during his medical training that performing an abortion

is a criminal offence.[82] As a result, he would turn away patients seeking an abortion, who would then be forced to get an unsafe abortion. He explained, "[w]e used to refuse a lot of them, and then three to four days later they are calling me for an emergency ward, and you have to provide emergency service. So you lose [patients' lives] and then you wonder [if] that is better than not helping them earlier."[83]

The widespread misconception that abortion is completely illegal does not diminish the number of abortions sought in Uganda; rather it causes more women to seek unsafe clandestine abortions.[84] The most recent studies estimate that approximately 362,000 induced abortions are performed in Uganda every year, and this figure has increased over the past several years.[85] An estimated 1,200 women die each year from unsafe abortions, while approximately 85,000 women undergo treatment for complications, and an additional 65,000 women experience complications but do not receive treatment.[86] The average woman in Uganda has a 50% chance of being treated for an abortion complication over the course of her lifetime.[87] Unsafe abortion is a major cause of Uganda's high maternal mortality rate,[88] particularly in comparison to global trends: the Ugandan Ministry of Health estimates that unsafe abortions cause about 18% of all deaths of women aged 15-49,[89] whereas 8% and 10% of maternal deaths worldwide and the sub-Saharan region respectively are the result of unsafe abortions.[90]

Furthermore, research shows that low-income women and those living in rural areas have limited access to safe abortion services.[91] Only 10% of low-income rural women can access safe abortion performed by doctors, whereas 50% of urban women in higher wealth quintile have access to this service.[92] Income level as a factor independent of geography also impacts access to safe abortion: doctors performed an estimated 37% of abortions for women with an income level above the national average and only 13% of abortions for women with an income level below the national average.[93] This income level-based disparity is primarily the result of unequal access to health care providers, because low-income women lack the resources to pay for travel expenses and for quality abortion services,[94] which cost significantly more if a women seeks care from a trained physician rather than from a traditional provider.[95] As a result, low-income women in Uganda are twice as likely as women with higher income to induce their own abortions and only one-third as likely to have their abortions performed by doctors.[96]

As documented in *The Stakes Are High*, Tewi, a 31-year-old woman who was living with HIV/AIDS, had to pay 200,000 Uganda Shillings (about USD 77) in order to procure a safe abortion from a doctor who performed the service clandestinely,[97] even though women living with HIV/AIDS are entitled to legal abortion services under the Health Ministry's Reproductive Health Guidelines.[98] She was only able to afford to pay such a high amount for a safe abortion because she had some personal wealth. She explained, "It was damn expensive, but I had to do it."[99] Likewise, a 2011 study estimated that women in Uganda pay an average of USD 62 for the direct costs of an abortion, including any PAC.[100] These costs are unaffordable for many women in Uganda, where about one quarter of the population lives below the poverty line of USD 1.25 per day.[101]

Insufficient Access to Post-Abortion Care (PAC)

According to Uganda's Reproductive Health Guidelines, post-abortion care (PAC) is a component of maternal and newborn health services in Uganda and should be provided to women who have had an abortion "of any cause."[102] The Reproductive Health Guidelines also requires PAC to be provided on a 24-hour basis[103] by doctors, midwives, or other trained professionals, and in facilities that meet minimum hygienic standards.[104] However, evidence shows that most health care facilities in Uganda are poorly equipped to manage PAC. Supplies that are crucial to the provision of PAC are only available in small

percentage of the health facilities that offer delivery services.[105] Health service providers receive less training in PAC than in almost any other skill area: according to the 2007 Uganda Service Provision Assessment Survey, the latest survey on this data, only 8% of providers received training in the year preceding the survey.[106] In addition, due to the misconception about the legality of abortion, discussed in the previous section, doctors may also refuse to perform PAC for fear of being reported to the police.[107]

A survey of Ugandan women also revealed that only 51% of low-income rural women who suffer abortion complications seek medical assistance:[108] most often, women do not seek medical treatment for abortions or related complications because they fear negative reactions and mistreatment from health care providers.[109] This deterrent from seeking needed medical treatment was also documented in *The Stakes Are High*. An interviewee named Maureen shared that her cousin died due to complications after a health worker pierced her intestine during an unsafe abortion procedure because he was "in a hurry to get out and go."[110] Maureen's cousin developed diarrhea but refused to seek help at a health facility because she feared that she would be stigmatized for having undergone an abortion. When her condition became unbearable, and she was admitted to a health facility she initially told the health workers she had malaria due to this fear. After her condition worsened, she told the health workers about the abortion, and was then referred to a hospital where she ultimately died.[111]

Ugandan women's fear of stigma is not unfounded: evidence shows that the negative attitudes of health care providers—often fuelled by their personal bias against abortion—also impact their provision of quality care to women seeking PAC services. In *The Stakes Are High*, Elizabeth, a medical doctor at Mulago Hospital, shared that her sister Martha faced stigma from the hospital staff after complaining of severe abdomen pain. Although Mulago is a major hospital in Kampala that provides PAC, the nurses abandoned Martha in the waiting area because they assumed the pain must be caused by an illegal abortion. Martha was left in the waiting area for a long time until Elizabeth managed to get her into surgery. Although surgery revealed that Martha's pain was caused by a burst dermoid cyst in her ovary, she was stigmatized throughout her time at the hospital, including in the recovery ward. Martha refused to go back to the hospital even when she later experienced some complications.[112] This account illustrates the unwelcoming environment prevalent in qualified health service facilities, which causes women to forgo quality care in hospitals, putting their lives and health at risk.

C. High Incidences of Preventable Maternal Mortality and Morbidity (Articles 2 (2), 3, 10 (2), 12)

WHO defines maternal death as any death that occurs during pregnancy, childbirth, or within 42 days after birth or termination of a pregnancy.[113] This Committee, as well as other treaty-monitoring bodies (TMBs), have framed the issue of maternal mortality as a violation of women's right to health and right to life.[114] Article 10 (2) of the CESCR explicitly grants special protection to women "during a reasonable period before and after childbirth."[115] Moreover, this Committee has made clear that states are under the obligation to introduce "measures to improve … maternal health ... including access to … pre- and postnatal care,"[116] and that the failure to lower the maternal mortality rate violates women's right to health under Article 12.[117] The CEDAW Committee, concerned over the "very high" maternal mortality in Uganda[118] has recommended that the government "strengthen its efforts to reduce the incidence of maternal and infant mortality."[119]

In the **LOIs**, the Committee asked the Government of Uganda to **"provide additional information on the impact of the implementation of laws and programmes aimed at reducing maternal … mortality**

rates, which remain high in the State party,"[120] as well as "steps taken to enhance access to antenatal and postnatal care…."[121] According to Uganda's State Party Report to the Committee, 63% of districts had begun implementing strategies outlined in the Roadmap as of FY 2009/2010.[122] However, these interventions do not seem to be improving the maternal mortality ratio (MMR). According to the government's 2013 Millennium Development Goal (MDG) Report, the MMR has not shown a statistically significant change over the past several years:[123] the ratio was 435 maternal deaths per 100,000 live births in 2006[124] and remained virtually unchanged in 2011 with an MMR of 438 maternal deaths per 100,000 live births.[125] A 2013 report from the WHO shows some improvement in the MMR at 360 deaths per 100,000 live births,[126] which is still a long way from the MDG goal of reducing the MMR to 131.[127] Moreover, in 2011, unsafe abortion accounted for 18% of all deaths of women aged 15–49.[128] For every maternal death, six women suffer severe morbidities such as anemia, infertility, pelvic pain, incontinence, and obstetric fistula.[129] In the MDG report, the government also acknowledged that progress towards reducing the MMR by three quarters is "stagnant" and it is unlikely that the goal will be met by 2015.[130]

In order to reduce the high mortality ratio, it is crucial that women and girls in Uganda have access to comprehensive maternal health services, including antenatal, delivery, and postnatal care. Although 95% of Ugandan women receive antenatal care at least once,[131] the percentage of women who attend the WHO recommended minimum of four antenatal visits,[132] has not improved in recent years: the 2006 UDHS reported that 47% of women made four antenatal visits, while the 2011 UDHS reported only 48% women received this level of care.[133] Furthermore, only 22% of the facilities that provide antenatal services in Uganda are equipped with the essential supplies necessary for basic ANC services.[134] Only 6% of facilities carry the minimum medications required to manage the most common life-threatening pregnancy complications, including anemia, pre-eclampsia, and eclampsia.[135]

Access to quality delivery care is also a serious problem in Uganda. According to the 2011 UDHS, 43% of women in Uganda give birth outside of a health care facility.[136] Of these women, 18% give birth with a traditional birth attendant, 15% are attended by a relative, and 7% give birth unattended.[137] While the number of births that have been attended by a skilled provider has increased from 42% in 2006[138] to 58% in 2011,[139] a significant percentage of births are still not attended by a skilled provider. Further, even if women seek delivery services in health care facilities, most of the facilities are not well equipped to provide comprehensive delivery services. The most recent available reports show that only about half of health care facilities offer basic delivery services,[140] only 5% offer cesarean section delivery,[141] and less than half of health care facilities are equipped with transportation for maternity emergencies.[142] Half of health care facilities are able to offer 24-hour delivery care by a trained medical provider, but only 5% have protocols in place for such services.[143] Further, just 5% of births occur in facilities that are equipped for emergency obstetric care,[144] and less than 3% of the health facilities are equipped to offer basic emergency obstetric care.[145]

Postnatal care is a critical component of preventing post-delivery maternal mortality:[146] WHO recommends at least three postnatal care visits, with the first occurring as early as possible within 24-hour window after an uncomplicated vaginal delivery.[147] However, only 64% of women in Uganda receive postnatal care in any form.[148] Of these women, only 21% receive care within the first 4 hours after delivery, while 33% receive care within the first two days.[149] Moreover, there is a significant income-based disparity in access to postnatal care: women in wealthiest 20% of households are twice as likely to receive postnatal care as women in the poorest 20% of households.[150]

In Uganda's 2012 Universal Periodic Review, the Human Rights Council recommended that the government raise the health budget to 15% in order to increase access to sexual and reproductive health services.[151] However, despite its expressed commitment to improving maternal health with the goal of reducing mortality and morbidity,[152] and its concern that the current MMR as "unacceptably high,"[153] the government has not implemented this recommendation and reproductive health services remain severely underfunded. The health sector budget was only about 8.6% of the total national budget in the 2013-2014 fiscal year [154] and 9% of the 2014-2015 budget.[155] Instead of improving, the budget allocation for health has decreased to 7% of the total budget for 2015-2016 fiscal year. [156] This funding falls short of the government's commitment to allocate at least 15% of the annual national budget to the health sector, as stipulated in the Abuja Declaration.[157] The failure to provide sufficient funding to the health sector, demonstrates a corresponding failure to prioritize maternal health issues, which results in insufficient antenatal, delivery, and postnatal care.

D. Adolescents' Access to Reproductive Health Care Information, Including Sexuality Education and Services (Articles 2 (2), 3, 12)

Adolescents often lack access to reproductive healthcare information and services, making them vulnerable to early pregnancies and sexually transmitted infections that may put their lives and health at risk.[158] This Committee and other TMBs have recognized that states' failure to provide sexuality education violates adolescents' basic human rights—including the right to health—and called on states to implement sexuality education programs in schools,[159] as well as in other youth-friendly settings.[160] Sexuality education contributes to the prevention of HIV and AIDS,[161] unwanted pregnancies,[162] unsafe abortion,[163] and maternal mortality.[164] It is crucial that sexuality education is age appropriate, comprehensive, non-discriminatory, and based on scientifically accurate information,[165] and that teachers receive "training in the specific skills needed to address sexuality clearly, as well as the use of active, participatory learning methods."[166]

In the **LOIs**, the Committee asked the Government of Uganda to address the issue of adolescents' access to sexual and reproductive health information and services, by requesting that the Government of Uganda **"indicate the steps taken to enhance access to sexual and reproductive health services and information, including access to contraceptives, … while indicating any existing disparity in such access, … of … age…."**[167] However, only half of sexually active adolescents in Uganda have received sexuality education in schools.[168] Thirty-nine percent of girls and 38% boys attend schools that do not provide any type of sexuality education.[169] Even when sexuality education is provided, it is not comprehensive. As one women's right advocate explains in *The Stakes Are High*, "[s]ex is taught with a lot of fear, taught with sugar coating and hiding."[170]

The lack of information and services contributes to Uganda's teenage pregnancy rate, which is one of the highest in the world.[171] The 2011 UDHS found that 20.8% of young women in Uganda began childbearing by age 17 and 48.7% had given birth to one or more children by age 19.[172] Adolescent pregnancy is of particular concern due to the link between young maternal age and increased risk of pregnancy-related complications, maternal mortality, and morbidity.[173] A 2015 study of girls' education in the West Nile region found that less than half of the girls surveyed knew how to prevent pregnancy, although one-quarter were sexually active.[174] The study found that 13% of girls who dropped out of school did so as the result of a pregnancy.[175] Although the National Adolescent Health Policy allows for the return of girls to school after a pregnancy, this policy is not enforced in practice, and there are no policies designed to encourage girls' re-entry.[176]

III. Discrimination against Women and Girls

Under the ICESCR, states have an "immediate and primary obligation"[177] to ensure the equal right of men and women to the enjoyment of all economic, social, and cultural rights set forth in the convention[178] and guarantee the exercise of these rights without discrimination on any prohibited grounds.[179] Particularly, the Committee has imposed upon the states an obligation to eliminate discrimination, specifically as expressed through "prejudices, customary and all other practices that perpetuate the notion of inferiority or superiority of either of the sexes, and stereotyped roles for men and women."[180] Similarly the African Charter and the Maputo Protocol require states to eliminate every discrimination against women[181] "though appropriate legislative, institutional and other measures,[182] including by undertaking measures to address the "social and cultural patterns" that perpetuate discrimination against women and girls.[183] In regards to Uganda, the CEDAW Committee has expressed concern over customs and practices in Uganda that perpetuate discrimination against women,[184] and called upon the government to address direct and indirect discrimination against women.[185] The Human Rights Council has recommended that Uganda adopt a comprehensive strategy to eliminate traditional practices and stereotypes that discriminate against women and that it revise and amend current legislation to ensure that it does not discriminate against women.[186]

A. Discrimination and Stigma against Women Living with HIV and AIDS (Articles 2 (2), 3, 12)

This Committee, in addition to other TMBs, has emphasized that states are obligated to guarantee the right to health of women living with HIV and prevent discrimination against women and girls based on their HIV status.[187] The Committee has stated that, "[s]tates have a special obligation … to prevent any discrimination on internationally prohibited grounds in the provision of health care and health services, especially with respect to the core obligations of the right to health."[188] Moreover, the Committee has stressed that states' obligations toward women living with HIV encompass the duty to guarantee access to reproductive health care information, goods, and services,[189] including treatment to reduce to the risk of parent-to-child HIV transmission.[190]

In the LOIs, the Committee asked the Government of Uganda to **"provide information on the contents of the new HIV Prevention and Control Act 2014, including on mandatory testing, criminalization and confidentiality.**"[191] This is in reference to the "HIV and AIDS Prevention and Control Act, 2014" (HIV Act),[192] that the Ugandan president signed into law in July 2014, which enshrines three provisions in particular that pose serious human rights violations for women living with HIV/AIDS.[193] First, the HIV Act requires mandatory HIV testing without informed consent, which violates the rights to health, privacy, and nondiscrimination enumerated in CESCR, as well as in CEDAW, ICCPR, and the Maputo Protocol.[194] The bill singles out women by subjecting pregnant women and survivors of sexual assault to compulsory HIV blood testing,[195] which deepens the stigma against women living with HIV and may deter women from seeking essential health care. The International Guidelines on HIV/AIDS and Human Rights recognizes that the compulsory testing of pregnant women is a coercive measure that ineffectively combats the spread of HIV and restricts the human rights of the individual,[196] and can result in "reduced participation and increased alienation of those at risk of infection."[197] Even when pregnant women learn of their HIV status, appropriate treatment is often not available. Preventing Mother-to-Child Transmission (PMTCT) treatment is only integrated into ANC and delivery services at 43% of health facilities in Uganda.[198] 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.

Second, the HIV Act allows health care providers to disclose the results of an HIV test to a patient's sexual partners without the patient's consent.[199] Non-consensual disclosure of HIV status places women at risk of physical, sexual, and psychological abuse. In 2008 alone, five women in Uganda were murdered by their husbands after the men learned about their wives' HIV-positive status.[200] A 2011 study reported that 29% women living with HIV experienced both physical and sexual violence from their intimate partners.[201] A more recent study also found that women feared increased domestic violence upon disclosure of their HIV status and persecution under the new law if their HIV status is revealed before their partners.[202] This may discourage women from seeking the necessary health care services, which is directly at odds with the goals of the government's HIV and reproductive health initiatives.[203]

Finally, the HIV Act criminalizes the intentional transmission of HIV and includes harsh penalties that would expose women living with HIV to greater risk of other human rights violations.[204] HIV testing is routinely provided as a part of prenatal care, making women more likely to learn about their HIV status and thus more likely to be accused by male partners of intentional HIV transmission. This could lead women to forego HIV treatment and care, making criminalization ineffective at containing the spread of HIV.

Recently, the High Court of Kenya found a similar provision in Kenya's HIV and AIDS Prevention and Control Act, No. 14 of 2006 to be unconstitutional.[205] Section 24 of this Act imposed criminal and financial penalties on any HIV positive person who knows his or her status and "knowingly or recklessly" puts another person at risk of being infected.[206] It also allows health care providers to disclose their patient's HIV status to a sexual partner without the patient's consent. In reaching its decision, the High Court held that this section "does not meet the principle of legality" and is likely to violate the right to privacy enshrined in the Constitution.[207]

B. Discrimination Causing Violence against Women and Girls (Articles 2 (2), 3, 10, 12)

Articles 10 and 12 of CESCR encompass protections for women prohibiting all forms of sexual and physical violence, while Articles 2 and 3 protect women from discrimination and inequality, which are root causes of gender-based violence.[208] The Committee has recognized that the implementation of Article 10 (1)—which provides protection to the family unity and guarantees free consent for marriage—obligates states to eliminate violence, and it emphasized that "[g]ender-based violence is a form of discrimination that inhibits the ability to enjoy rights and freedoms…."[209] Moreover, the Committee has noted the serious effects of violence against women on their physical and mental health and has advised states parties to adopt effective measures to combat it.[210] In 2010, the CEDAW Committee, while commending the Government of Uganda for passing the "Domestic Violence Act 2010," expressed concern over the high prevalence of violence against women and girls and called upon the state to give the issue "priority attention."[211]

In the LOIs, the Committee asked the Government of Uganda to **"update the Committee on the status of the Sexual Offences Bill … [and] provide information on the impact of measures taken under the Domestic Violence Act … to reduce gender-based violence, which remains prevalent in the State party."**[212] In Uganda's current State Party Report to this Committee, however, the government did not provide information on its implementation of the Domestic Violence Act, or on any other measures undertaken to curb the root causes of violence, beyond that it is "in the process of developing a GBV [gender-based violence] policy to guide actors in handling GBV."[213] Key domestic stakeholders—such as the National Association of Women Judges-Uganda (NAWJU)—have criticized the government for its failure to implement the Domestic Violence Act: officials from state institutions, including police officers and judges, have systemically failed to apply the new legislation and often lack awareness that the Act was

passed.[214] In April 15, the high number of incidents of domestic violence prompted Archbishop Cyprian Kizito Lwanga to express concern that "[f]amilies have become places of fear and oppression…. Domestic violence not only shatters homes but also … society as a whole."[215]

Likewise, the proposed Sexual Offences Bill, if passed, will be equally ineffective in reducing sexual violence without the full buy-in of state institutions to implement and enforce the bill's expanded protections for women.[216] Although the current draft of the Sexual Offences Bill includes some essential legal reforms, such as the criminalization of marital rape, the Bill should be amended so that marital rape is not categorized as a separate offense from rape with a heightened standard of proof.[217] Under the Bill, the marriage relationship may be used as a defense unless it is shown that the victim spouse was sick, the accused spouse had an STI, one spouse "deserted," or the accused spouse used "violence or threats."[218] Other common law jurisdictions have amended rape statutes to eliminate historical distinctions based on marital status.[219] Moreover, the Bill would be improved with the inclusion of services for survivors of violence, such as a full range of "comprehensive, gender-sensitive health services,"[220] including access to legal abortion, emergency contraception,[221] and post-exposure prophylaxis to protect against HIV infection.[222]

Due to the government's failure to effectively implement legal and policy measures, violence against women and girls remains alarmingly high. According to the 2011 UDHS, 56% of women age 15-49 have experienced physical violence at least once since the age of 15, and 28% have experienced sexual violence.[223] Six out of ten of ever married women in the same age group reported experiencing emotional, physical, or sexual violence from their spouse.[224] This level of violence has not shown any notable improvement from 2006 when 60% of women reported having experienced physical violence at least once since the age of 15,[225] and 68% of Ugandan women reported having suffered physical, sexual, or emotional violence at the hands of their current or former husband or partner.[226] Further, according to the most recent reports from the Ugandan Police, reports of domestic violence increased by 18.4%—from 2,793 cases reported in 2012 to 3,426 cases in 2013.[227] It is very unlikely that this increase in the number of victims of gender-based violence—which is chronically underreported—is the result of any improvement in services to victims that would encourage more women to report the crimes to law enforcement. Even when women report sexual violence, they frequently face indifference to these crimes by the Uganda Police and impunity for their assailants. In 2013, 1,365 rape cases were reported, out of which only 365 were taken to court and a mere 11 cases (0.8%) resulted in convictions.[228] Further, out of the 19,508 defilement cases reported, only 9,598 were investigated and 359 cases (1.8%) resulted in convictions.[229]

Violence against children is also a grave problem in Uganda. A 2014 study found that 95% of children reported having experienced physical, sexual, or emotional violence,[230] and over 75% in a 2005 study reported having experienced some kind of sexual violence or harassment.[231] Among these children, 24% reported that the sexual violence they suffered occurred mainly at school, while 34% reported that the abuse happened both at home and at school.[232] A 2007 study found that 23% of girls reported that their first sexual encounter was forced.[233] In addition, a 2010 report shows that 8% of girls age 16-17 have had sex with their teachers.[234] Two primary reasons that girls are coerced into having sex with a teacher is that school girls are afraid of the consequences of refusing a teacher's sexual advances, and that teachers lure girls with the promise of good grades or gifts.[235] The Center welcomes the Committee's request in the LOIs for the Government of Uganda to **"indicate steps taken to improve quality of education and qualifications and skills of teachers,"**[236] and recommends the consideration of the impact of sexual violence in schools on girls' right to education and reproductive health.

In addition to the absence of an effective legal framework, many factors contribute to the continuation of the violence against women and girls in Uganda. One such factor is the perpetuation of cultural and societal views that place women at an inferior position to men and normalize gender-based violence. Joyce, as reported in *The Stakes Are High*, experienced domestic violence as a result of her husband's misconception about contraception. He beat her severely after he found out that she has been using contraception for six years.[237] When she reported him to the police, he abandoned her and their five children.[238] This example highlights the need for holistic services for victims of domestic violence, including shelters and programs that enable women to develop economic self-sufficiency.[239]

Female Genital Mutilation

In the **LOIs**, the Committee asked the Government of Uganda to **"provide information on the impact of measures taken under … the Prohibition of Female Genital Mutilation Act to reduce gender-based violence, which remains prevalent in the State party."**[240] FGM was criminalized in Uganda under the Prohibition of Female Genital Mutilation Act and also found to be inconsistent with Uganda's Constitution and international treaty obligations in a 2010 Constitutional Court decision.[241] Although approximately only 1% of the women in the country have undergone FGM, according to the 2011 and 2006 UDHS, [242] the practice remains prevalent in the Karamoja and Eastern regions and among the Pokot and Sabiny ethnic groups, which have FGM rates of about 95% and 50% respectively.[243] Although community level engagement has generated some support from community leaders to end the practice, significant challenges remain.[244] Following the enactment of the Prevention of Female Genital Mutilation Act, there has been an increase in families crossing the border to seek FGM for daughters in western Kenya.[245] Moreover, the implementation of the law among these communities in isolated areas remains relatively ineffective. There is a general lack of access to law enforcement and courts due to geographic location, as well as a lack of willingness to report cases due to strong community cohesion.[246]

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

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

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

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

d. What concrete steps are the government taking to meet its commitment to reducing the maternal mortality rate in Uganda to 132 deaths per 100,000 live births by 2015? How does the government plan to expand the availability of and access to emergency obstetric care

and decrease the number of complications from deliveries not performed by skilled providers?

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

f. Have structures been set up to tackle the rights violations experienced by women living with HIV/AIDS? In particular, will the government amend provisions in the HIV and AIDS Prevention and Control Act that require compulsory HIV testing of pregnant women and disclosure of results without consent, and the criminalization of and harsh penalties for the intentional transmission of HIV, among other violations?

g. What steps will the government take to gather updated information about sexual violence? How does the government plan to combat impunity for those who commit acts of sexual violence? What steps are the government taking to ensure the implementation of the Domestic Violence Act and amend the provisions of the proposed Sexual Violence Bill that are of concern, particularly the heightened standard of proof for marital rape, before the passing of the Bill? What steps are the government taking to implement the Female Genital Mutilation Act and reduce the rate in regions where the practice is prevalent?

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

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

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

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

d. The government should provide sexuality education to all adolescents, both in and out of school, and incorporate sexual and reproductive health education into school curriculum in

order to address the prevalence of unplanned pregnancy among adolescents. It should also adopt measures to ensure adolescents' ease of access to contraception without the risk of stigma or violence.

e. The government should implement strategies to reduce the stigmatization and discrimination faced by women living with HIV/AIDS, especially in health care facilities. The government should examine and amend the laws and policies already in place to ensure that they prevent and prohibit discrimination against those living with HIV/AIDS. Further, it should amend the provisions in the HIV and AIDS Prevention and Control Act that require compulsory HIV testing, disclosure of results without consent, and criminalization of HIV transmission, all of which violate human rights and are counterproductive to providing effective health care.

f. The government should effectively implement the Domestic Violence Act by ensuring that state officials, including judges and police officers, understand the law and are applying it in practice. The government should institute investigation procedures and strict punishments for those found to have abused children. These procedures should include an oversight mechanism to help regulate and eradicate sexual and other violence against children, including violence committed in schools. The government should revise the provisions in the Sexual Offences Bill that are of concern, particularly those requiring a heightened standard of proof for marital rape, and include full range of comprehensive and gender-sensitive services for victims of violence. The government should develop a concrete plan to implement the Female Genital Mutilation Act and educate the community where the practice is prevalent on its harmful effect.

We hope this information is useful during the Committee's review of Uganda. If you have any questions, or would like further information, please do not hesitate to contact the undersigned.

Evelyne Opondo
Regional Director
Africa Program
Center for Reproductive Rights

Onyema Afulukwe
Senior Legal Advisor
Africa Program
Center for Reproductive Rights

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[1] International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976) (*ratified by* Uganda Jan. 21, 1987) [hereinafter ICESCR].

[2] Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), *adopted* Dec. 18, 1979, G.A. Res. 34/180, 34 U.N. GOAR, Supp. No. 46, at 193, U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981) (*ratified by* Uganda Jul. 22, 1985) [hereinafter CEDAW]; International Covenant on Civil and Political Rights (ICCPR), *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into* force Mar. 23, 1976) (*ratified by* Uganda Jun. 21, 1995) [hereinafter ICCPR]; African Charter on Human and Peoples' Rights, *adopted* June 27, 1981, O.A.U. Doc. CAB/LEG/67/3, rev. 5, 21 I.L.M. 58 (1982) (*entered into force* Oct. 21, 1986) (*ratified by* Uganda May 10, 1986) [hereinafter African Charter]; Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2nd

Ordinary Sess., Assembly of the Union, *adopted* Jul. 11, 2003, CAB/LEG/66.6 (*entered into force* Nov. 25, 2005) (*ratified by* Uganda Jul 22, 2010) [hereinafter Maputo Protocol].
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[4] Human Rights Committee, *Concluding Observation: Jordan*, para. 7, U.N. Doc. CCPR/C/JOR/CO/4 (2010).
[5] Human Rights Committee, *General Comment No. 28: Article 3 (The equality of rights between men and women)*, (68th Sess., 2000), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 3, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) (emphasis added).
[6] Human Rights Committee, *Concluding Observation: Dominican Republic*, para. 10, U.N. Doc. CCPR/C/DOM/CO/5 (2012).
[7] Human Rights Committee, *Concluding Observation: Guatemala*, para. 8, U.N. Doc. CCPR/C/GTM/CO/3 (2012).
[8] Human Rights Committee, *Concluding Observation: Cape Verde*, para. 8, U.N. Doc. CCPR/C/CPV/CO/1 (2012).
[9] Human Rights Committee, *Concluding Observation: Canada*, para. 20, U.N. Doc. CCPR/C/79/Add.105 (1999).
[10] Committee on Economic, Social and Cultural Rights (ESCR Committee), *General Comment No. 16: The equal right of men and women to the enjoyment of all economic, social and cultural rights (Art. 3)*, (34th Sess., 2005), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, paras. 7-8, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *General Comment No. 16*].
[11] *Id.* paras. 6-7.
[12] *Id.* para. 7.
[13] *Id.* para. 9.
[14] *Id*. para. 15.
[15] *Id.*
[16] Rebecca Cook, *Human Rights and Reproductive Self Determination*, 44 THE AMERICAN UNIVERSITY LAW REVIEW 975, 1007 (1995).
[17] *Id*.
[18] CEDAW Committee, *General Recommendation No. 24: Article 12 of the Convention (women and health)*, (20th Sess., 1999), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, art. 24, para. 31(e), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW *General Recommendation No. 24*].
[19] ICESCR, *supra* note 1, art. 12.
[20] ESCR Committee, *General Comment No. 14: The right to the highest attainable standard of health (Art. 12)*, para 8 (22nd Sess., 2000), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 14, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *Gen. Comment No. 14*)
[21] *Id*. para 21.
[22] *Id*. para. 14.
[23] *See, e.g.*, ESCR Committee, *Concluding Observations: Armenia*, para. 15, U.N. Doc. E/C.12/1/Add.39 (1999); *Cameroon*, para. 25, U.N. Doc. E/C.12/1/Add.40 (1999); *Dominican Republic*, para. 15, U.N. Doc. E/C.12/1/Add.16 (1997); *Dominican Republic*, para. 22, U.N. Doc. E/C.12/Add.6 (1996); *Honduras*, para. 27, U.N. Doc. E/C.12/1/Add.57 (2001); *Paraguay*, para. 16, U.N. Doc. E/C.12/1/Add.1 (1996); *Poland*, para. 12, U.N. Doc. E/C.12/1/Add.26 (1998); *Saint Vincent and the Grenadines*, para. 12, U.N. Doc. E/C.12/1/Add.21 (1997); *see also see also* CENTER FOR REPRODUCTIVE RIGHTS ET AL., BRINGING RIGHTS TO BEAR: AN ANALYSIS OF THE WORLD OF U.N. TREATY MONITORING BODIES ON REPRODUCTIVE AND SEXUAL RIGHTS 117 (2002).
[24] ESCR Committee, *Concluding Observations: Dominican Republic*, paras. 28-29, U.N. Doc. E/C.12/DOM/CO/3 (2010); *see also* ESCR Committee, *Concluding Observations: Philippines,* para. 31, U.N. Doc. E/C.12/PHL/CO/4 (2008); *Nicaragua,* paras. 26-27, U.N. Doc. E/C.12/NIC/CO/4 (2008); *Azerbaijan*, para. 30, U.N. Doc. E/C.12/1/Add.104 (2004); *Poland*, para. 12, U.N. Doc. E/C.12/1/Add.26 (1998).
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[26] ESCR Committee, *Concluding Observations: Kenya*, para. 33, U.N. Doc. E/C.12/KEN/CO/1 (2008).
[27] ESCR Committee, *Concluding Observations: Russian Federation*, para. 30, U.N. Doc E/C.12/RUS/CO/5 (2011).
[28] CEDAW Committee, *Concluding Observations: Uganda*, para. 36, U.N. Doc. CEDAW/C/UGA/CO/7 (2010).

[29] ESCR Committee, *List of issues in relation to the initial report of Uganda*, para. 29, U.N. Doc. E/C.12/UGA/Q/1 (2014) [hereinafter ESCR Committee, *List of Issues, Uganda*].
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[33] MINISTRY OF HEALTH, UGANDA SERVICE PROVISION ASSESSMENT SURVEY 2007 88 (2008) [hereinafter PROVISION ASSESSMENT].
[34] 2011 UDHS, *supra* note 27, at 79.
[35] 2011 UDHS, *supra* note 32, at 79.
[36] SUSHEELA SINGH ET AL., UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA: CAUSES AND CONSEQUENCES 19-20 (2006), *available at* http://www.guttmacher.org/pubs/2006/11/27/UgandaUPIA.pdf [hereinafter UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA].
[37] *See* 2011 UDHS, *supra* note 32, at 81.
[38] *See* Human Rights Watch, How can we survive here?: The impact of Mining on Human Rights in Karamoja, Uganda (2014).
[39] *See* 2011 UDHS, *supra* note 32, at 81.
[40] UGANDA PROVISION ASSESSMENT, *supra* note 33, at 92.
[41] 2011 UDHS, *supra* note 32, at 93-96.
[42] UGANDA PROVISION ASSESSMENT, *supra* note 33, at 97.
[43] John B Asiimwe et al., *Factors Associated with Modern Contraceptive Use among Young and older Women in Uganda; A Comparative Analysis*, 14 BMC PUBLIC HEALTH 926 (2014)*, available at* http://www.biomedcentral.com/1471-2458/14/926.
[44] UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA, *supra* note 36, at 22.
[45] STAKES ARE HIGH, *supra* note 3, at 44.
[46] *Id.*
[47] *Id.* at 45.
[48] GUTTMACHER INSTITUTE, *Benefits of Meeting the Contraceptive Needs of Ugandan Women, In Brief: No. 4* 4 (2009), available at http://www.guttmacher.org/pubs/IB_Contraceptive-Needs-Uganda.pdf [hereinafter *Benefits of Meeting Needs*].
[49] STAKES ARE HIGH, *supra* note 3, at 54.
[50] UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA, *supra* note 36, at 22.
[51] *See* STAKES ARE HIGH, *supra* note 3, at 42-43.
[52] *Id.*
[53] *Id.* at 48.
[54] *Id.*
[55] *Id.* at 50.
[56] A. Kalangwa, *AWLN Uganda and RHU advocate for closing of the funding gap for FP and RH commodities in the FY 2014/2015 budget*, AFRICAN WOMEN LEADERS NETWORK FOR REPRODUCTIVE HEALTH & FAMILY PLANNING, (2014), http://www.africawln.org/awln-uganda-and-rhu-advocate-for-closing-of-the-funding-gap-for-fp-and-rh-commodities-in-the-fy20142015-budget/ (last visited Mar. 13, 2015).
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[58] ICESCR, *supra* note 1, art. 15(b).
[59] WHO, *Emergency Contraception Fact Sheet No. 244* (Nov. 2012), http://www.who.int/mediacentre/factsheets/fs244/en/ [hereinafter WHO, *Emergency Contraception*].
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[61] Josaphat K. Byamugisha et al., *Emergency Contraception and Fertility Awareness among University Students in Kampala, Uganda* 6 AFR. HLTH. SCIENCES NO. 4 56 (2006) [hereinafter Byamugisha].
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[63] 2011 UDHS, *supra* note 32, at 78.
[64] Byamugisha, *supra* note 61, at 56-57.
[65] *See Id*. at 22-23.
[66] *Id.* at 48.
[67] *See Id.*
[68] *See* WHO, *Emergency Contraception*, *supra* note 59.
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[72] CEDAW Committee, *Concluding Observations: Uganda*, para. 35, U.N. Doc. CEDAW/C/UGA/CO/7 (2010).
[73] CEDAW Committee, *Concluding Observations: Uganda*, para. 147, U.N. Doc. A/57/38 (2002).
[74] *Id*. para. 148.
[75] ESCR Committee, *List of Issues, Uganda*, *supra* note 29, para. 30.
[76] CONSTITUTION OF THE REPUBLIC OF UGANDA (1995), art. 22(2); Penal Code Act, Cap. 120, sec. 244 (Uganda).
[77] In *Rex v. Bourne*, the court held that an abortion would not be "unlawful" if done "in good faith for the purpose only of preserving the life of the mother" and that "if the doctor is of the opinion, on reasonable grounds and with adequate knowledge, that the probable consequence of the continuance of the pregnancy will be to make the woman a physical or mental wreck," then it constitutes acting in preservation of the life of the woman. *See* Rex v. Bourne, [1939] 1 K.B. 687.
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[81] *Id.* at 29.
[82] STAKES ARE HIGH, *supra* note 3, at 32.
[83] *Id.* at 32.
[84] *Id.* at 24.
[85] *Benefits of Meeting Contraceptive Needs*, *supra* note 48, at 5; *see* UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA, *supra* note 36, at 4, 6, 25.
[86] UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA, *supra* note 36, at 5, 6, 17.
[87] *Id.* at 5.
[88] CEDAW Committee, *Concluding Observations: Uganda*, para. 35, U.N. Doc. CEDAW/C/UGA/CO/7 (2010).
[89] 2011 UDHS, *supra* note 32, at 237, tbl. 15.3.
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[93] Health providers with some formal training performed an estimated 68% of abortions for women with an income level above the national average and only 50% of abortions for women with an income level below the national average. UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA, *supra* note 26, at 11.
[94] ABORTION & POST-ABORTION CARE IN UGANDA, *supra* note 91.
[95] For example, abortion performed by a doctor would cost between USD 25 - USD 88 compared to USD 12 - USD 34 if performed by a traditional healer and USD 4 - USD 14 if a woman self-induces. *See* ABORTION & POST-ABORTION CARE IN UGANDA, *supra* note 91, at 6.
[96] UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA, *supra* note 36, at 4.
[97] STAKES ARE HIGH, *supra* note 3, at 20.
[98] NATIONAL POLICY GUIDELINES, *supra* note 78, at 45.
[99] *Id.* at 20.
[100] Aparna Sundaram et al. *Documenting the Individual- and Household-Level Cost of Unsafe Abortion in Uganda*, 39 INT'L PERSP. SEX. & REPROD. HEALTH (Dec. 2013), *available at*

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[103] *Id.* at 46.
[104] *Id.* at 48.
[105] UGANDA PROVISION ASSESSMENT, *supra* note 33, at 132.
[106] *Id.* at 136, tbl. 6.13.
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[112] *Id. at* 16.
[113] WHO ET AL., TRENDS IN MATERNAL MORTALITY: 1990-2013 4 (2014), *available at* http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2013/en/ [hereinafter TRENDS IN MATERNAL MORTALITY].
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[117] *Id.* para. 52.
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[127] MDG REPORT, *supra* note 123, at 24, tbl. 7.
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[134] UGANDA PROVISION ASSESSMENT, *supra* note 33, at 114.
[135] *Id.* at 115.
[136] *Id.* at 105.
[137] *Id.* at 112.
[138] 2006 UDHS, *supra* note 31, at 128.
[139] 2011 UDHS, *supra* note 32, at 112.
[140] UGANDA PROVISION ASSESSMENT, *supra* note 33, at 124.
[141] *Id.*
[142] 2006 UDHS, *supra* note 31, at 125. The 2011 UDHS does not include any updates on this data.
[143] *Id.* at 128.

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[152] REPUBLIC OF UGANDA, MINISTRY OF HEALTH, NATIONAL HEALTH POLICY 1999, para. 2.4 (1999).
[153] Uganda State Party Report, *supra* note 30, para. 172.
[154] *Id.* at 121.
[155] UGANDA, NATIONAL BUDGET FRAMEWORK PAPER, *supra* note 57, Annex 6, at 704.
[156] *Id*. at 39.
[157] ABUJA DECLARATION ON HIV/AIDS, TUBERCULOSIS AND OTHER RELATED INFECTIOUS DISEASES, para. 26 OAU/SPS/ABJUA/3 (2001).
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[159] *See, e.g.,* CEDAW *General Recommendation No. 24*, *supra* note 18, para. 23; ESCR Committee, *Concluding Observations: Armenia*, para. 22(b), U.N. Doc. E/C.12/ARM/CO/2-3 (2014); *People's Republic of China (including Hong Kong and Macao)*, para. 100, U.N. Doc. E/C.12/1/Add.107 (2005); *Poland*, paras. 28 & 50, U.N. Doc. E/C.12/1/Add.82 (2002); *Senegal*, para. 47, U.N. Doc. E/C.12/1/Add.62 (2001); *Ukraine*, para. 31, U.N. Doc. E/C.12/1/Add.65 (2001); Human Rights Committee, *Concluding Observations: Poland*, para. 9, U.N. Doc. CCPR/CO/82/POL (2004); CEDAW Committee, *Concluding Observations: Burundi*, para. 62, U.N. Doc. A/56/38 (2001); *Republic of the Congo*, para. 228, U.N. Doc. A/55/38 (2000); Committee on the Rights of the Child, *Concluding Observations: Bhutan*, para. 45, U.N. Doc. CRC/C/15/Add.157 (2001); *Comoros*, para. 36, U.N. Doc. CRC/C/15/Add.141 (2000); *Egypt,* paras. 43-44, U.N. Doc. CRC/C/15/Add.145 (2001).
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[176] *Id.* at 12.
[177] ESCR Committee, *General Comment No. 16: The equal right of men and women to the enjoyment of all economic, social and cultural rights (Art. 3)*, (34th Sess., 2005), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 40, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee*, Gen. Comment No. 16*].
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[183] *Id.* art. 2(2).
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[187] *See* ESCR Committee, *Concluding Observations: Belarus*, para. 24(b), U.N. Doc. E/C.12/BLR/CO/4-6 (2013); *Angola*, para. 15, U.N. Doc. E/C.12/AGO/CO/3 (2008); *Kenya*, para. 32, U.N. Doc. E/C 12/KEN/CO/1 (2008); CEDAW Committee, *General Recommendation No. 15: Avoidance of discrimination against women in national strategies for the prevention and control of acquired immunodeficiency syndrome (AIDS)*, (9 Sess., 1990), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 327, para. (d), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008); Committee on the Rights of the Child, *General Comment No. 3: HIV/AIDS and the rights of the child*, (32 Sess., 2003), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 398, paras. 5-7, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008); Human Rights Committee, *Concluding Observations: Trinidad and Tobago*, para. 11, U.N. Doc. CCPR/CO/70/TTO (2000); *see also* JOINT UNITED NATIONS PROGRAMME ON HIV AND AIDS (UNAIDS), 26TH MEETING OF THE UNAIDS PROGRAMME COORDINATING BOARD NON-DISCRIMINATION IN HIV RESPONSES 4-5 (2010), *available at* http://www.unaids.org/en/media/unaids/contentassets/documents/priorities/20100526_non_discrimination_in_hiv_en.pdf.
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[217] The Sexual Offences Bill categorizes "rape under marriage" as a separate offense from rape that requires a heightened standard of proof: the marriage relationship may be used as defense unless it is shown that the victim spouse was sick, the accused spouse had an STI, the accused spouse used "violence or threats," or one spouse "deserted." *Id.* Part II, sec. 3. By contrast, the crime of "rape" is more broadly defined as occurring, inter alia, "by force or by means of threats or intimidation of any kind or by fear of bodily harm." *Id.* Part I, sec. 1, "Rape".
[218] Sexual Offences Act 2011, Bill No. 1, Part II, sec. 3, "Rape under marriage" (2011) (Uganda).
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consensual "penetration" and "touching" where "B does not consent … and A does not reasonably believe that B consent," without reference to the marital status of A and B); New York Pen. Law § 130.25 (U.S.) (defining rape in the third degree as, *inter alia*, when "[a person] engages in sexual intercourse with another person without such person's consent…." without reference to marital status in any degree of rape).

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[233] Ann Moore et al., *Coerced First Sex among Adolescent Girls in Sub-Saharan Africa: Prevalence and Context*, 11 AFR. K. REPROD. HLTH. NO. 3 62, 63-67 (2007).

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[235] *Id.*

[236] ESCR Committee, *List of Issues, Uganda*, *supra* note 29, para. 32.

[237] STAKES ARE HIGH, *supra* note 3, at 45.

[238] *Id.*

[239] INTERNATIONAL FEDERATION FOR HUMAN RIGHTS (FIDH) ET AL., WOMEN'S RIGHTS IN UGANDA: GAPS BETWEEN POLICY AND PRACTICE 15 (2012), *available at* https://www.fidh.org/IMG/pdf/uganda582afinal.pdf.

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[241] *See, e.g.*, Lydia Mukisa, *Female genital mutilation illegal, court rules*, THE MONITOR (Jul. 30, 2010), *available at* http://www.monitor.co.ug/News/National/-/688334/967406/-/x2p1c1/-/index.html.

[242] 2006 UDHS, *supra* note 31 at 135.

[243] UNFPA, DRIVING FORCES IN OUTLAWING THE PRACTICE OF FEMALE GENITAL MUTILATION/CUTTING IN KENYA, UGANDA AND GUINEA-BISSAU 16 (2013), *available at* http://www.unfpa.org/sites/default/files/resource-pdf/Legislation%20and%20FGMC.pdf.

[244] *Id*. at 18.

[245] *Id*.

[246] *Id*.