

October 8, 2014

The Africa Commission on Human and Peoples' Rights

Re: Supplementary Information on Uganda scheduled for review by the Africa Commission on Human and Peoples' Rights during its 56th Ordinary Session

Introduction

This letter is intended to supplement the periodic report submitted by Uganda, to the African Commission on Human and Peoples' Rights (the African Commission) in keeping with Article 62 of the Africa Charter on Human and Peoples' Rights (Africa Charter),¹ which will be reviewed by the Commission. The Center for Reproductive Rights (the Center), a global legal advocacy organization with headquarters in New York, and offices in Nairobi, Bogotá, Kathmandu, Geneva, and Washington, D.C., and the Center for Health, Human Rights and Development (CEHURD) a Ugandan non-governmental organization hope to further the work of the Commission by providing independent information on the rights protected in the African Charter, the Protocol of the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol)², and the African Charter on the Rights and Welfare of the Child (African Children's Charter)³.

The letter provides information on the following issues of greatest concern: lack of access to comprehensive family planning services and information, lack of access to safe abortion services and post-abortion care, the high rates of preventable maternal mortality and morbidity; discrimination against people living with HIV and AIDS; and discrimination against women and girls, including violence, and forced pregnancy testing and expulsion of pregnant school girls. The information in this letter regarding unsafe abortion and lack of access to family planning information and services is drawn from the Center's fact-finding report, *The Stakes are High: The Tragic Impact of Unsafe Abortion and Inadequate Access to Contraception in Uganda* (the Stakes are High),⁴ which has been submitted with this letter.

I. The Rights 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.

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Accordingly, states are required to address both de jure and de facto discrimination in private and public spheres.⁵ They are further required to not only remove barriers but also take positive measures “to achieve the effective and equal empowerment of women.”⁶ To this end, they should ‘adopt whatever legislation is necessary to give full effect to the principle of equality between men and women,’⁷ develop policies that promote gender equality,⁸ take efforts to eliminate gender stereotypes about women in the family and society,⁹ and address practices that disproportionately impact women.¹⁰

Similarly, it has been affirmed that to fulfill women’s human rights, states must use all appropriate means to promote substantive equality, including by adopting temporary special measures.¹¹ To this end, the Committee on the Elimination of Discrimination against Women (CEDAW Committee) has noted that “women be given an equal start and that they be empowered by an enabling environment to achieve equality of results” and that “[t]he position of women will not be improved as long as the underlying causes of discrimination against women, and of their inequality, are not effectively addressed.”¹²

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.¹³ As such, it is crucial that women have access to reproductive health services, and that those services can be accessed with their consent alone.¹⁴ 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.”¹⁵

II. THE RIGHT TO REPRODUCTIVE HEALTHCARE (ARTICLES 2, 4 AND 16 OF THE AFRICAN CHARTER, AND ARTICLES 2,3,4, AND 14 OF THE MAPUTO PROTOCOL)

Article 4 of the African Charter guarantees the right to life, while Article 16 recognizes the right to enjoy the best attainable state of physical and mental health, and obligates states to take necessary measures to ensure their people’s health.¹⁶ Similarly, both the Maputo Protocol and the African Children’s Charter recognize the right to health of women and children.¹⁷ International human rights standards that guarantee the right to life have been interpreted to require governments to take “positive measures” aimed at preserving life.¹⁸ Such measures should respond equally to the needs of men and women in keeping with Articles 2 and 3 of the African Charter, which guarantee equality before the law and equal enjoyment of the rights and freedoms recognized in the Charter.

These provisions obligate the Ugandan government to ensure women’s and girls’ access to reproductive healthcare services as lack of access to these services could have grave consequences on their life and health. In the absence of these services, women and girls may experience unwanted pregnancies, and unsafe pregnancies and deliveries, possibly exposing

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

In order to monitor the implementation of the rights stipulated in the international and regional instruments Uganda is a party to, it is required, under Article 62 of the Africa Charter to submit a report on “legislative or other measures taken, with a view to giving effect to the rights and freedoms recognised and guaranteed in the [charter].”¹⁹ This reporting requirement also extends to the rights and freedoms guaranteed in the Maputo Protocol²⁰ and the Africa Children’s Charter.²¹ It is regrettable, however, that the government of Uganda, in its report submitted to the Africa Commission, failed to provide information on the measures it is has undertaken to ensure that the reproductive rights of women and girls’ are respected, protected and fulfilled. Apart from acknowledging that the maternal mortality rate is “unacceptably high”, the government did not address the measures, if any, it is undertaking to curb this high rate. Similarly, the government’s report is silent on women’s and adolescent girls’ access to safe abortion and contraceptive information and services, which are an integral component for the realization of their reproductive rights.

A. Access to Comprehensive Family Planning Services and Information

Access to family planning services and information is critical to protecting women’s and girls’ rights to life and health. The Maputo Protocol explicitly requires states to ensure that the sexual and reproductive rights of women, including the right to control their fertility, the right to decide whether and when to have children, and the right to choose any method of contraception is respected.²² In order to effectuate these rights, the states are expected to not only ensure that women have access to a full range of contraceptives but also that they have all the necessary information to make informed choices.

It is commendable that access to family planning information and services in Uganda has shown some improvement throughout the years. The latest Demographic Health Survey (UDHS) shows that the unmet need for contraceptives decreased from 41% in 2006²³ to 34% in 2011,²⁴ while the use of modern contraception increased from 15% in 2007²⁵ to 26% in 2011.²⁶ However, about three quarters of Ugandan women still do not use modern contraception and²⁷ 42% of pregnancies in Uganda (a minimum of 775,000 each year) are unintended.²⁸ Also, the rate of usage of contraceptives varies depending on the level of education, geographical location and wealth quintiles. For instance, 44% of currently married women with secondary or more education are using a contraceptive method compared to only 18% of the married women who have no education.²⁹

Many factors, including user fees, unavailability of a preferred contraceptive method,³⁰ improper counseling services,³¹ lack of information about contraceptives, and absence of necessary

supplies to insert certain methods³² contribute to Uganda's low contraceptive prevalence rate. One survey revealed that fear of side effects, inconvenience of using modern contraceptives, partners opposing contraceptive use, and belief that contraceptives are prohibited by religion inhibit women from using modern contraceptives.³³ Similar results were documented in the Center's publication, the *Stakes are High*. In one instance, Nansubuga, a woman who lives in Kampala, talks about discontinuing the use of contraceptives because she believed that one could not get pregnant after having used family planning for a long time.³⁴ However, she conceived immediately after she stopped using the pill temporarily and ultimately underwent a clandestine abortion.³⁵ Joyce, another woman interviewed for the study, told us how her husband beat her because of his misconception about contraceptive use saying: "He didn't want me to take the pills because [he said] they destroy a woman's reproductive health. [He said they] also destroy their sexual urge. That's what he told me and he gave me a thorough beating. He beat me very badly; all of my body was swollen."³⁶

Others reported hesitance to obtain contraceptives because using or even discussing contraceptives could imply infidelity.³⁷ As one interviewee noted, "women exercising control over their own reproductive choices are often suspected of being unfaithful to their husbands or engaging in other illicit activities."³⁸ In addition, lack of information about the different contraceptive methods and where to access them is a significant barrier to access. One research found that 13% of women surveyed indicated that they did not know where they could obtain contraceptives or they could not access a health center that offers contraceptives.³⁹ In the Center's publication, Edith, a sex worker, explains having to go through an unplanned and unwanted pregnancy and multiple unsafe abortions because she didn't have knowledge and information about contraceptive methods and services.⁴⁰ She noted that her life changed once she had access to family planning services.⁴¹

Lack of equality and discrimination against women—demonstrated through their lack of autonomy to decide whether and when to have children, and providers' negative attitude towards women and girls who are not married but seek contraceptive services—is also a major barrier to use. The power imbalance between men and women often makes it difficult for women to negotiate contraceptive use, especially male controlled methods such as condoms, with their partners.⁴² As one volunteer in one local clinic in Kampala noted:

"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."⁴³

Women also face discrimination in healthcare facilities as they are often asked for spousal consent before they can access family planning services, even though this is not required under Uganda's laws and policies.⁴⁴ In addition to women who are married, this practice is particularly

discriminatory towards unmarried women and adolescents as they are not able to produce such consent.

Emergency Contraception (EC): 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 could reduce the number of unintended pregnancy and unsafe abortions.⁴⁵ The Ministry of Health officially introduced EC in 1998.⁴⁶ However, its use and awareness of the method by women remains low.⁴⁷ 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.⁴⁸ The 2011 DHS has also reported that only 31% of women know about EC.⁴⁹

Healthcare workers also lack accurate information about EC and display bias which reduces its use and acceptance.⁵⁰ There is insufficient training on the proper use of, and counseling on, EC.⁵¹ Common misperceptions about EC include the notion that it will inhibit future fertility, cause extreme side effects,⁵² and encourage sexual promiscuity.⁵³ However, these perceptions are unfounded as the World Health Organization (WHO) has noted that the side-effect of EC are uncommon and generally mild, and do not affect fertility.⁵⁴

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

Unsafe abortion is one of the most easily preventable causes of maternal mortality and morbidity. When it does not result in death, complications arising from unsafe abortion can, and often do, expose women to the risk of long-term disabilities, such as uterine perforation, chronic pelvic pain, or infertility.⁵⁵ The importance of safeguarding women's life and health, and protecting the reproductive rights of women, is explicitly enshrined in the Maputo Protocol under Article 14(2) (c), which requires states to authorize abortion in cases of sexual assault, rape, incest, and when continued pregnancy endangers the mental and physical health or life of the women or the fetus.⁵⁶ Although the Ugandan government has ratified the Maputo Protocol and has repeatedly recognized unsafe abortion as a leading cause of maternal mortality and morbidity,⁵⁷ the government has entered a reservation on this article which would have expanded access to safe abortion.

Uganda's laws and policies on abortion are highly restrictive and unclear, leading to greater numbers of unsafe, clandestine abortions. Under the Constitution and the Penal Code, abortion is allowed only when the woman's life is in danger.⁵⁸ Pre-independence jurisprudence, which still applies in Uganda, clarifies that the life exception in the Penal Code also includes physical and mental health.⁵⁹ Further, the *Uganda National Guidelines and Services Standards for Sexual and Reproductive Health and Rights* (Reproductive Health Guidelines) provide expanded grounds for permitting legal abortion, such as sexual violence and incest, and outline comprehensive abortion

and post-abortion care standards.⁶⁰ However, the limited interpretations of the legal framework by the courts and other government bodies, and the extremely restricted access to relevant information, have resulted in lack of comprehensive information about the law among women, healthcare providers, law enforcement, the judiciary, and regulators, among others.⁶¹

As research shows, most doctors and other trained providers mistakenly believe that abortion is completely prohibited and are reluctant to provide the comprehensive services outlined in the Reproductive Health Guidelines, for fear of being subjected to criminal liability under the Penal Code.⁶² Dr. Andrew, an interviewee who has practiced gynecology for 20 years, noted he used to tell the women who came to him seeking abortion “get out from my sight” because he was told, during his medical training, that abortion is a criminal offence.⁶³ Because of this belief, he said, “[w]e used to refuse a lot of them, and then three to four days later they are calling me for an emergency ward, and you have to provide emergency service. So you lose [patients’ lives] and then you wonder [if] that is better than not helping them earlier.”⁶⁴

The widespread misconception that abortion is completely illegal does not diminish the number of abortions sought in Uganda; rather, as evidence shows, it causes more women to seek unsafe clandestine abortions.⁶⁵ Most recent estimates state that approximately 362,000 induced abortions are performed in Uganda every year, a figure that has increased over the past several years.⁶⁶ About 1,200 women die each year from unsafe abortions while approximately 85,000 receive treatment for complications, and approximately 65,000 experience complications but receive no treatment.⁶⁷ The average woman in Uganda has a 50% chance of being treated for an abortion complication over the course of her lifetime.⁶⁸

Also, research shows that low-income women and those living in rural areas have limited access to safe abortion services.⁶⁹ A study reports that 29% of unintended pregnancies in the Kampala region, the country’s most urbanized region, end in abortion whereas in the other more rural regions, between 12% and 20% end in abortion.⁷⁰ Only 10% of poor rural women can access safe abortion performed by doctors as opposed to 50% of non-poor urban women.⁷¹ Wealth affects access too: among unintended pregnancies in the wealthiest quintile of women, 23% end in abortion, whereas for women in the poorest quintile of the population, only 14% end in abortion.⁷²

The primary reason for this difference is unequal access to healthcare providers: women with higher income tend to—and can afford to—seek abortion care from skilled healthcare providers whereas low-income women, especially those living in rural areas, have less access to doctors and are more likely to rely on unsafe abortion services provided by unskilled providers or to induce abortion themselves.⁷³ Low-income women in Uganda are two times as likely to induce their own abortions and only one-third as likely to have their abortions performed by doctors, as compared to women.⁷⁴ Further, the cost of obtaining an abortion from a physician is significantly higher than that of a traditional provider.⁷⁵ 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.⁷⁶ 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 an abortion from a doctors.⁷⁷ She noted that she was only able to afford to pay such a high amount for a safe abortion because she had some personal wealth. Still, she said “It was damn expensive, but I had to do it.”⁷⁸ These costs are unaffordable for many women in Uganda—about one quarter of the population lives below the poverty line of USD 1.25 per day.⁷⁹

As a result, women—particularly low-income women and adolescents—have to resort to self-induced abortion using crude and unsafe methods, or seek the services of unskilled providers working in unsafe conditions, with grave risk to their health and life. In the *Stakes are High* Nicki shared the experiences of girls who she knows to have self-induced:

“I used to live in a place where a girl got pregnant and she used Omo, the detergent. She drank it with warm water and ended up bleeding. Her parents didn’t know, nobody knew, only her friends. She had to be taken to a clinic to check on her.”⁸⁰

“Another friend, used tea—majan—leaves. She took a first glass—it’s sour. It didn’t work. She took a second one. She ended up falling down, bleeding, asking for help In that process she was injured, she lost a lot of blood. She was taken by a relative to a healthcare facility.”⁸¹

Another interviewee, a government lawyer who has prosecuted abortion cases under the penal code, told about the case of one girl saying: “[the unsafe abortion provider] brought her to a lodge in [a town], and it is not known what method he had her use, but she ended up dead in that lodge because of over bleeding.”⁸²

Although there is no comprehensive data on the number of maternal deaths that result from unsafe abortion, the Ugandan Ministry of Health estimates that the figure is about 26%,⁸³ indicating that clandestine abortions are a major cause of Uganda’s high maternal mortality rate.⁸⁴ The CEDAW Committee has articulated its concern over this issue,⁸⁵ especially in respect to adolescent girls,⁸⁶ and recommended that Uganda implement national reproductive health programs to prevent unsafe abortions.⁸⁷

Post-Abortion Care (PAC)

According to Uganda’s Reproductive Health Guidelines, PAC is a component of maternal and newborn health services in Uganda, and should be provided to women who have had an abortion “of any cause.”⁸⁸ It also requires PAC to be provided on a 24-hour basis,⁸⁹ by doctors, midwives and other trained professionals, in a place where minimum hygienic conditions are met.⁹⁰

However, evidence shows that most healthcare facilities in Uganda are poorly equipped to manage PAC. Vacuum aspirators⁹¹ and dilation and curettage (D&C)⁹² kits—supplies crucial to

the provision of PAC—are only available in 22% and 14%, respectively, of the health facilities offering delivery services.⁹³ Health service providers receive less training in PAC than almost any other area of skills training, with just 8% of providers receiving training in the year preceding the 2007 Uganda Service Provision Assessment Survey, the latest survey on this data.⁹⁴ 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.⁹⁵ Also, when low-income women in Uganda do receive PAC from doctors, it is usually in government hospitals, which do not always offer the most advanced and safest procedures, compared to private hospitals.⁹⁶ Only 51% of poor rural women who suffer abortion complication seek medical assistance.⁹⁷ Even when women seek PAC, “the drugs, equipment, and skills are insufficient.”⁹⁸ In addition, doctors may also refuse to perform PAC for fear of being reported to the police.⁹⁹

Further, a survey of Ugandan women also revealed that women do not seek medical treatment for abortions or related complications because of fear of negative reactions and mistreatment from healthcare providers.¹⁰⁰ Maureen, an interviewee, spoke about her cousin who suffered complications and died due to an unsafe abortion performed by a health worker who pierced her intestine because he was “in a hurry to get out and go.”¹⁰¹ She developed diarrhea but tried to control it through self-medication as she feared mistreatment if she goes to a medical facility. Maureen’s cousin suffered for a week before her condition became unbearable and she was admitted to a health facility. For fear of stigmatization, she initially told the health workers she had malaria. After her condition worsened, she told the health workers about the abortion and was then referred to a hospital but ultimately died.¹⁰²

This fear of stigma, however, is not unfounded as evidence shows that the negative attitude of healthcare providers, often fuelled by their personal bias about abortion, also impacts their provision of quality care to women perceived to be seeking PAC services. For example in the Center’s publication, Elizabeth, a medical officer at Mulago Hospital that provides PAC, talks about her sister Martha, who faced stigma when she went to the hospital complaining of severe pains. Upon telling the nurses that she had once had an abortion, they assumed she had had an illegal abortion and practically abandoned her in the waiting area. Martha was left in the waiting area for a long time until Elizabeth called a colleague who managed to get her into surgery. Martha was stigmatized throughout her time at the hospital including in the recovery ward, although surgery revealed that Martha’s pain was caused by a burst dermoid cyst in her ovary. Martha refused to go back to the hospital even when she later experienced some complications.¹⁰³ This account illustrates the unwelcoming environment prevalent in qualified health service facilities and how the hostile environment often leads women to seek out back-door clinics or other care for PAC and ultimately only seeking care in a hospital when it is almost too late.

C. High Incidences of Preventable Maternal Mortality and Morbidity

The WHO defines maternal death as any death that occurs during pregnancy, childbirth, or within 42 days after birth or termination of a pregnancy.¹⁰⁴ The committees that monitors compliance with various international human right treaties— the International Covenant on Economic, Social and Cultural Rights (ICESCR), the International Covenant on Civil and Political Rights (ICCPR), and the Convention on the Elimination of all forms of Discrimination against Women (CEDAW)—have all framed the issue of maternal mortality as a violation of women’s right to health and right to life.¹⁰⁵ The CEDAW Committee, concerned over the “very high” maternal mortality in Uganda¹⁰⁶ has recommended that the government “strengthen its efforts to reduce the incidence of maternal and infant mortality.”¹⁰⁷

However, the maternal mortality ratio (MMR), as per the government’s 2013 Millennium Development Goal (MDG) Report, has not shown statistically significant change:¹⁰⁸ the ratio was 435 in 2006¹⁰⁹ and 438 maternal deaths per 100,000 live births in 2011,¹¹⁰ with maternal deaths accounting for 18% of all deaths of women aged 15-49.¹¹¹ In addition, for every maternal death, 6 women suffer severe morbidities such as anemia, infertility, pelvic pain, incontinence, and obstetric fistula.¹¹² In the MDG report, the government also acknowledges that it is unlikely that the goal of reducing the MMR by three quarters by 2015 will be met.¹¹³

While Uganda has expressed its commitment to improving maternal health with the goal of reducing mortality and morbidity,¹¹⁴ and described the current MMR as “unacceptably high,”¹¹⁵ reproductive health services are still severely underfunded. The budget allocation for the health sector for 2012-2013 only accounted for 7.8% of the total government’s budget,¹¹⁶ and the budget for 2013-2014 was only 8.6%.¹¹⁷ This falls short of the government’s commitment to allocate at least 15% of the annual national budget to the health sector as stipulated in the Abuja Declaration.¹¹⁸ The failure to provide sufficient funding to the health sector, which would also have an affect maternal health services, demonstrates a corresponding failure to prioritize maternal health issues, which results in insufficient antenatal, delivery, and post-partum care.

Antenatal Care (ANC)

In Uganda, the number of women who receive ante-natal care (ANC) has steadily remained at 95%.¹¹⁹ The quality of ANC also has improved, with more women being informed of complications during pregnancy, more women having their blood pressure measured, and more women reporting having had urine samples taken.¹²⁰ However, the average gestational age at the first ANC visit and the number of women who receive the WHO recommended minimum of four ANC visits¹²¹ has remained largely unchanged over the past decade: the 2006 UDHS reported 5.5 months and less than half of women getting minimum visits while in the 2011 UDHS reported 5.1 months and 48% only getting minimum visits.¹²² Furthermore, only 22% of the facilities that provide ANC services in Uganda are equipped with the essential supplies necessary for basic ANC services,¹²³ and only 6% of facilities carry the minimum medications required to manage common but life-threatening pregnancy complications including anemia, pre-eclampsia and eclampsia.¹²⁴

Delivery Care

Access to quality delivery care is a serious problem in Uganda, and a significant contribution to its unacceptably high maternal mortality rate. Maternal mortality and morbidity are caused, in part, by a majority of deliveries occurring outside of health facilities without skilled attendants, and by delays in seeking care, barriers in access to care, and limited capacity, resources, supplies, and skills available in health facilities.¹²⁵ According to the 2011 UDHS, 43% of women in Uganda give birth outside of a healthcare facility,¹²⁶ among which 18% give birth with a traditional birth attendant, 15% are attended by a relative, and 7% give birth unattended.¹²⁷ While the number of births that have been attended by a skilled provider has increased from 42% in 2006¹²⁸ to 58% in 2011,¹²⁹ still a significant percentage of births are unattended by a skilled provider. The figure is also not demonstrative of the situation in specific parts of Uganda, as only 35% of births in Northern Uganda are attended by a trained professional of any kind.¹³⁰

Even women who do give birth in a healthcare facility are not free from risk. The most recent data available from Uganda reports that only about half of healthcare facilities offer basic delivery services,¹³¹ one quarter are able to provide minimum health services on a 24-hour basis,¹³² only 5% offer cesarean section delivery¹³³ (and only two thirds of those have anesthetists on staff),¹³⁴ and less than half of healthcare facilities are equipped with transportation for maternity emergencies.¹³⁵ One third of facilities have the basic equipment needed for normal deliveries,¹³⁶ less than half of facilities are equipped with the essential supplies necessary to prevent infection during delivery,¹³⁷ and only 10% have the requisite sterilization materials.¹³⁸ Half of healthcare facilities are able to offer 24-hour delivery care by a trained medical provider, but only 5% have protocols in place for such services.¹³⁹

Further, the availability of emergency obstetric care and other emergency procedures that may be necessary during delivery is severely limited. Just 5% of births occur in facilities that are equipped for emergency obstetric care,¹⁴⁰ and only a small fraction (less than 3%) of the facilities that are expected to be able to offer basic emergency obstetric care could in fact offer it.¹⁴¹ The lack of emergency services, supplies, transportation, and skilled providers available has led to 86% of women, who should have had some form of obstetric intervention, not being able to get it.¹⁴² This extremely high number highlights the preventable nature of maternal mortality and morbidity in the country.

Post-natal Care (PNC)

The WHO defines post-natal care (PNC) as the management of care for mother and infant up to 42 days after delivery.¹⁴³ The first 24 hours after delivery are the most critical to preventing post-delivery maternal mortality, and the provision of PNC is an essential component.¹⁴⁴ Despite the known importance of PNC, 64% of women in Uganda receive no PNC at all.¹⁴⁵ Of the women that do receive PNC, only 21% receive care within the first 4 hours after delivery while 33% receive care within the first two days.¹⁴⁶

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

Adolescents often lack access to reproductive healthcare information and services making them vulnerable to risks to their life and health due to early pregnancies and sexually transmitted infections.¹⁴⁷ International human rights treaty monitoring bodies recognize that sexuality education contributes to the prevention of HIV and AIDS,¹⁴⁸ adolescent and unwanted pregnancies,¹⁴⁹ unsafe abortion,¹⁵⁰ and maternal mortality.¹⁵¹ Where adolescents are not provided with comprehensive sexuality education, it hinders the realization of their human rights by inhibiting their knowledge about, and access to sexual and reproductive health services. Furthermore, treaty monitoring bodies have urged states to implement sexuality education programs in all schools¹⁵² as well as in other settings in order to reach adolescents who are not enrolled in schools.¹⁵³ To comply with human rights standards, therefore, sexual and reproductive health information and education should be comprehensive, unbiased, and scientifically accurate.¹⁵⁴

Despite this, research has revealed that only half of sexually active adolescents in Uganda receive sexuality education in schools.¹⁵⁵ 39% of girls and 38% boys attend schools that do not provide any type of sexuality education.¹⁵⁶ Even when sexuality education is provided in schools, it is not comprehensive: as one women's right advocate explains, "Sex is taught with a lot of fear, taught with sugar coating and hiding."¹⁵⁷

The lack of information and services contributes to high rates of teenage pregnancy, leading Uganda to have one of the highest teen pregnancy rates in the world.¹⁵⁸ As of 2011, 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 19.¹⁵⁹ Adolescent pregnancy is of particular concern due to the association between young maternal age and the greater risk of maternal mortality and morbidity, and pregnancy related complications.¹⁶⁰

In addition to the proven greater risk unplanned and unwanted pregnancy poses to young women,¹⁶¹ they suffer additional risks because of fear of repercussions from their family, community, or schools. The *Stakes are High* documented the stories of adolescent girls who became pregnant and subsequently put themselves in danger by procuring unsafe abortion rather than disclosing their pregnancies. Hajara's teenage daughter became pregnant at school and sought out a clandestine abortion without her mother's knowledge. Following the unsafe abortion, Hajara's daughter hid for several days and thought she was going to die. Fortunately, she was found by some neighbors and Hajara brought her daughter back to the abortion providers and forced them to finish the abortion. Had the neighbors not found her in time, Hajara's daughter could have died from the unsafe abortion.¹⁶²

Similarly, Nicki, explains in detail the lengths adolescents will go in order to terminate their own pregnancies in efforts to avoid being abandoned by their families or suffering other stigma or

rejection from their community. She describes the dangerous methods employed by her friends, describing that “a girl got pregnant and she used Omo, the detergent. She drank it with warm water and ended up bleeding.” Another friend “used tea – majan – leaves. She took a first glass – it’s sour. It didn’t work. She took a second one. She ended up falling down, bleeding, asking for help... In that process she was injured, lost a lot of blood.”¹⁶³ These methods pose enormous risks, yet adolescent girls feel compelled to use them because the consequences seem less severe than the alternative of telling their families.¹⁶⁴ Although, in 2013, a government official stated that the government is planning to introduce sexuality education as a comprehensive subject in schools,¹⁶⁵ there is no information about the topics that will be covered under the subject and whether this has been implemented.

III. DISCRIMINATION AGAINST WOMEN AND GIRLS

The right to equality and non-discrimination is a core principle that underlies international and regional human rights standards. The Africa Charter requires states to eliminate “every discrimination against women and girls and also ensure the protections of the rights of the woman and the child.”¹⁶⁶ Similarly, the Maputo Protocol obligates states to “combat all forms of discrimination against women through appropriate legislative, institutional and other measures,”¹⁶⁷ including by undertaking measures to address the “social and cultural patterns” that perpetuate discrimination against women and girls.¹⁶⁸ The ESCR Committee has also 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.”¹⁶⁹ The CEDAW Committee has expressed concern over customs and practices in Uganda that perpetuate discrimination against women,¹⁷⁰ and called upon the government to address direct and indirect discrimination against women.¹⁷¹ 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.¹⁷²

A. Discrimination and Stigma against Women with HIV and AIDS

Discrimination and stigma against people with HIV is a human rights violation.¹⁷³ The CESCR has noted that, “[s]tates have a special obligation . . . to prevent any discrimination on internationally prohibited grounds in the provision of health care and health services, especially with respect to the core obligations of the right to health.”¹⁷⁴ Its General Comment 14 also reiterates state obligations to fulfill “the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups,”¹⁷⁵ including women.

People living with HIV suffer stigma and discrimination in Uganda,¹⁷⁶ with women living with HIV frequent victims of violence because of their HIV status.¹⁷⁷ As a result of the stigma

associated with HIV, many women fear learning and disclosing their HIV status for fear of violence or eviction.¹⁷⁸

In May 2014, the Ugandan Parliament passed the “HIV and AIDS Prevention and Control Bill, 2010” (the HIV Bill).¹⁷⁹ The bill was previously shelved on account of intensive advocacy against it. Despite the continued advocacy, the bill was signed into law by the president in July 2014.¹⁸⁰ Several of the HIV Bill’s provisions threaten to negatively impact women living with HIV, such as mandatory testing without patient consent in certain circumstances.¹⁸¹

The HIV Bill’s provisions that require mandatory HIV testing without informed consent violate the right to health, privacy and nondiscrimination enumerated in the Covenant, CEDAW, ICCPR and the Maputo Protocol.¹⁸² Compulsory testing of pregnant women may deter women from seeking healthcare, directly contravening the Ugandan government’s ability to prevent the spread of HIV and make improvements in maternal health care. The International Guidelines on HIV/AIDS and Human Rights recognize that the compulsory testing of pregnant women is a coercive measure that ineffectively combats the spread of HIV and restricts the human rights of the individual¹⁸³ which can result in “reduced participation and increased alienation of those at risk of infection.”¹⁸⁴ Even when pregnant women learn their HIV status, appropriate treatment is often not available. Preventing Mother-to-Child Transmission (PMTCT) treatment is only integrated into ANC and delivery services at 43% of health facilities in Uganda.¹⁸⁵ Rather than focusing on compulsory testing of pregnant women, efforts would be better directed at strengthening the delivery of maternal health and PMTCT services and increasing women’s confidence in maternal health services.

The HIV Bill contains two more provisions of particular relevance and risk to women. The first allows healthcare providers to release results of an HIV and AIDS test to a patient’s sexual partners without the patients consent, potentially exposing the patient to stigma, discrimination, and violence.¹⁸⁶ If women believe their HIV status may be disclosed, they may be discouraged from seeking the necessary healthcare services, contradicting government HIV and reproductive health initiatives.¹⁸⁷ The second provision criminalizes intentional transmission of HIV and includes harsh penalties that would expose women living with HIV to more risks of human rights violations.¹⁸⁸ HIV testing is routinely provided as a part of prenatal care, making women more likely to learn about their HIV status and similarly more likely to be accused of intentional HIV transmission. This could lead women to forego HIV treatment and care, making criminalization ineffective at containing the spread of HIV.

B. Violence against Women and Girls

In 2010, the CEDAW Committee, while commending the government for passing the Domestic Violence Bill, expressed concern over the high prevalence of violence against women and girls, and called upon the state to give the issue “priority attention”.¹⁸⁹ However, in the report submitted to the Commission, even though the government stated that it has passed the Domestic

Violence Act, it did not provide information on its implementation as well as legislative and other measures undertaken to curb the root causes of violence and harmful traditional practices such as early marriage.

Due to the government's failure to effectively address the situation, violence against women and girls remains alarmingly high. According to the 2011 UDHS, 56% of women age 15-49 have experienced physical violence at least once since the age of 15 and 28% have experienced sexual violence.¹⁹⁰ Six in ten ever married women in the same age group reported having experienced emotional, physical, or sexual violence from their spouse.¹⁹¹ This level of violence has not shown any improvement from 2006 when 60% of women reported having experienced physical violence at least once since the age of 15.¹⁹² In the same year, 66% of Ugandan women also reported having suffered sexual violence at the hands of their current or former husband or partner.¹⁹³ Further, according to the most recent reports from the Uganda Police, reports of domestic violence increased by 18.4%: from 2,793 cases reported in 2012 to 3,426 cases in 2013.¹⁹⁴ Also, 360 deaths resulted from domestic violence—among which 159 were females—an increase from 277 deaths reported in 2012.¹⁹⁵ Even when sexual violence is reported, women frequently face indifference to these crimes and impunity for their assailants. In 2013, 1,365 rape cases were reported, out of which only 365 were taken to court and a mere 11 resulted in convictions.¹⁹⁶ Further, out of the 19,508 defilement cases reported, only 9,598 were investigated and 359 convicted.¹⁹⁷

Violence against children is also a grave problem in Uganda. A 2005 study found that 98% of children reported having experienced physical or emotional violence with over 75% reporting having experienced some kind of sexual violence or harassment.¹⁹⁸ Among these children, 24% reported that the sexual violence they suffered occurred mainly at school while 34% reported that the abuse happened at home and at school.¹⁹⁹ Two years later, another study found that 23% of girls reported that their first sexual encounter was forced.²⁰⁰ In addition, a 2010 report shows that 8% of girls age 16-17 have had sex with their teachers.²⁰¹ Two primary reasons are the fear amongst school girls of the consequences of refusing a teacher's sexual advances as well as the practice of teachers luring girls into having sex by promising them good grades or gifts.²⁰²

Many factors contribute to the continuation of the violence against Uganda women and girls. Cultural and societal views, which place women at an inferior position that men, and normalize violence against them, are one such factor. Joyce, as reported in the *Stake are High*, experienced domestic violence as a result of her husband's misconception about contraception. He beat her ruthlessly after he found out that she has been using contraception for six years.²⁰³ He then run away, leaving her to fend for herself and their five children, when she reported him to the police.²⁰⁴

The WHO recognizes that violence against women is a violation of women's human rights which can lead to a variety of physical, mental, and other health problems.²⁰⁵ Similarly, health practitioners recognize the many consequences of violence affecting women including

psychological impact and diminished capacity to participate in public life.²⁰⁶ The breadth and depth of the effects of violence against women is likely even greater because it is largely under-reported.²⁰⁷ The African Commission, recognizing the grave consequences of violence against women, has urged states to “[i]dentify the causes and consequences of sexual violence and to take all necessary measure to prevent and eradicate it.”²⁰⁸ The Commission has also urged states to ensure access to medical assistance and psychological support to victims of violence, as well as “efficient and accessible reparation programmes that ensure information, rehabilitation and compensation for victims of sexual violence.”²⁰⁹ Specifically, in its concluding observations on Uganda, the Commission urged the government to “[u]rgently introduce laws to criminalize violence against children ... and measures that will help towards the total eradication of all the harmful cultural practices in Uganda....”²¹⁰

C. Coercive Pregnancy Testing and Expulsion of Pregnant School Girls

Both the Africa Charter and the Africa Children’s Charter recognize that everyone has the right to education.²¹¹ Further, the Maputo Protocol obligates states to “eliminate all forms of discrimination against women and guarantee equal opportunity and access” to education.²¹² Article 10 of CEDAW also protects the rights of women and girls to an education and obligates states to reduce female student dropout rates and to organize programs for those who have left school prematurely.²¹³ Further the ESCR Committee affirms that education plays a vital role in empowering women and safeguarding children from sexual exploitation.²¹⁴

In Uganda, coercive pregnancy testing of schoolgirls and the expulsion of pregnant school girls is a common practice that threatens their ability to exercise their right to education. While there is no official data on the frequency of the practice, individual statements attest to personal experiences and those of others that demonstrate its prevalence. The story of Evelyn Evans Lanyero, a Ugandan victim turned advocate, who has a first-hand experience of the practice is one example.²¹⁵ Evelyn recounts that, at the age of 14, she was called into the senior teacher’s office at her school and told to undress. The senior teacher then proceeded to “examine” Evelyn’s eyes, palms, stomach, and breasts by running her hands all over Evelyn’s body. Only after she had finished did the senior teacher inform Evelyn that she had been looking for signs of pregnancy. Evelyn stated that these tests were very common while she was in school, and that if there was strong suspicion of pregnancy, the tests would progress from just physical to including a urine test. Most often, girls who are found to be pregnant are expelled from school and are rarely, if at all, allowed to return.

A 2013 article reported that it is common for schools to conduct pregnancy testing at the beginning of every term with some conducting the test even at the end of the term.²¹⁶ The article further revealed that those found to be pregnant are expelled.²¹⁷

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

- a. What measures are being taken to address the lack of information about family planning, including myths and misconceptions about the side-effects of contraception? What steps is the government undertaking to ensure sufficient supplies of family planning and contraceptive methods? What steps is the government taking to improve awareness about, and the availability of, emergency contraception?
- b. Given the widespread misperception that abortion is completely illegal, what concrete measures are being taken to promote national awareness of the legal grounds for abortion? What other measures are being taken to review the existing abortion laws, health policies, and guidelines to ensure they are consistent with international and regional human rights standards?
- c. How will the government reduce the high levels of unsafe abortions in Uganda? What steps has the government taken to ensure equal opportunities for rural and low-income women and adolescents to receive respectful and comprehensive post-abortion care?
- d. What concrete steps is the government taking to meet its commitment to reducing the maternal mortality rate in Uganda to 132 deaths per 100,000 live births by 2015? How does the government plan to expand availability of and access to emergency obstetric care and decrease the number of complications from deliveries not performed by skilled providers?
- e. Has the government implemented its plans to introduce sexuality education in schools? What measures has it taken to ensure that sexuality education is comprehensive and scientifically accurate? What efforts have been made to reduce the high rates of adolescent pregnancy including by providing adequate reproductive and sexual health services and information?
- f. 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?
- g. Have structures been set up to tackle the rights violations experienced by people living with HIV/AIDS? In particular, will the government amend provisions in the HIV and AIDS Prevention and Control Bill which require compulsory HIV testing of pregnant women and disclosure of results without consent, among other violations?
- h. What steps have been taken to gather comprehensive data about and address coerced pregnancy testing and expulsion of schoolgirls? What measures are being

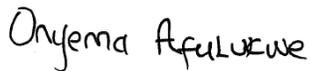
undertaken to ensure that girls who get pregnant in schools are allowed to continue with their education and re-enroll after giving birth?

D. We hope that the Commission will consider making the following recommendations to the government of Uganda

- a. The government should take concrete steps to ensure an adequate and consistent supply of contraceptives, including emergency contraceptives, initiate civic education campaigns to ensure sufficient and non-discriminatory access to family planning information and services and develop comprehensive guidelines obligating healthcare facilities to provide accurate and comprehensive family planning information, without discrimination.
- b. The government should remove its reservation on Article 14 of the Maputo Protocol and review its abortion law to ensure it is consistent with international and regional human rights standards. It should implement nationwide awareness raising strategies to dispel the misperceptions about when abortion is legal, and increase the number of health facilities that can provide legal and safe abortion and comprehensive post-abortion care services, including in rural areas.
- c. Uganda should increase the number of healthcare facilities equipped and staffed to handle basic and emergency obstetric care, especially in low-income and rural areas, and increase the number of skilled healthcare providers able to offer quality ante-natal, delivery, and post-natal care. The government should also facilitate reliable and affordable transportation to quality healthcare facilities for pregnant women in low-income and rural areas to reduce preventable maternal mortality.
- d. The government should provide sexuality education to all adolescents, in and out of school, and incorporate sexual and reproductive health education as a part of the curriculum in schools to address the prevalence of unplanned pregnancy among adolescents. It should also adopt measures to ensure ease of access of contraception for adolescents without risk of stigma or violence.
- e. The government should institute investigation procedures and strict punishments for those found to have abused children. These procedures should include an oversight mechanism to help regulate and eradicate sexual and other violence against children, including those committed in schools.
- f. The government should implement strategies to reduce stigmatization and discrimination of persons living with HIV and AIDS, especially in healthcare facilities. It should ensure that the laws and policies already in place prevent and prohibit discrimination against those living with HIV and AIDS. Further, it should amend the provisions in the HIV and AIDS Prevention and Control Bill that

require compulsory HIV testing, disclosure of results without consent, and criminalization of HIV transmission which are counterproductive to providing effective healthcare and violate human rights.

- g. The government should prohibit coerced pregnancy testing and expulsion of schoolgirls, track and develop comprehensive data on the incidence, and ensure that students who become pregnant in school are able to continue with their education.



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- ¹ African Charter on Human and Peoples' Rights, *adopted* June 26, 1981, art. 62, O.A.U. Doc. CAB/LEG/67/3/Rev.5, 21 I.L.M. 58 (1982) (*entered into force* Oct. 21, 1986) (*ratified* Nov. 17, 1989) [hereinafter African Charter].
- ² Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2nd Ordinary Sess., Assembly of the Union, *adopted* July 11, 2003, art. 4(1), 5 CAB/LEG/66.6 (*entered into force* Nov. 25, 2005) (*ratified* May 20, 2005) [hereinafter Maputo Protocol].
- ³ African Charter on Rights and Welfare of the Child, *adopted* July 11, 1990, OAU Doc. CAB/LEG/24.9/49 (*entered into force* Sept. 17, 1999) (*ratified* 17 Sept. 1999) [hereinafter African Children's Charter].
- ⁴ The report was published by the Center, O'Neill Institute for National and Global Health Law and the International Women's Human Rights Clinic at Georgetown Law in 2013.
- ⁵ Human Rights Committee, *Concluding Observation: Jordan*, para. 7, U.N. Doc. CCPR/C/JOR/CO/4 (2010).
- ⁶ 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).
- ⁷ Human Rights Committee, *Concluding Observation: Dominican Republic*, para. 10, U.N. Doc. CCPR/C/DOM/CO/5 (2012).
- ⁸ Human Rights Committee, *Concluding Observation: Guatemala*, para. 8, U.N. Doc. CCPR/C/GTM/CO/3 (2012).
- ⁹ Human Rights Committee, *Concluding Observation: Cape Verde*, para. 8, U.N. Doc. CCPR/C/CPV/CO/1 (2012).
- ¹⁰ Human Rights Committee, *Concluding Observation: Canada*, para. 20, U.N. Doc. CCPR/C/79/Add.105 (1999).
- ¹¹ Committee on the Elimination of Discrimination against Women (CEDAW Committee), *General Recommendation No. 28: The Core Obligations of States Parties under Article 2 of the Convention on the Elimination of All Forms of Discrimination against Women*, (47th Sess., 2010), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, para. 20, U.N. Doc. CEDAW/C/GC/28 (2010).
- ¹² CEDAW Committee, *General Recommendation No. 25: Article 4, Paragraph 1 of the Convention (Temporary special Measures)*, (30th Sess., 2004), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, paras. 8 & 10, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008).
- ¹³ Rebecca Cook, *Human Rights and Reproductive Self Determination*, 44 *The American University Law Review* 975, 1007 (1995).
- ¹⁴ *Id.*
- ¹⁵ 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*].
- ¹⁶ *Id.*, art. 4 ("Human beings are inviolable. Every human being shall be entitled to respect for his life and the integrity of his person. No one may be arbitrarily deprived of this right."); *Id.*, art. 16(1) ("Every individual shall have the right to enjoy the best attainable state of physical and mental health."); *Id.*, art. 16(2) ("States Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.").
- ¹⁷ See Maputo Protocol, *supra* note 2, art. 14; Children's Charter, *supra* note 3, art. 14.
- ¹⁸ Human Rights Committee, *General Comment No. 6: Right to life*, (16th Sess., 1982), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, art. 6, para. 5, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008).
- ¹⁹ African Charter, *supra* note 1, art. 62.
- ²⁰ Maputo Protocol, *supra* note 2, art. 26.
- ²¹ African Children's Charter, *supra* note 3, art. 43(1).
- ²² Maputo Protocol, *supra* note 2, arts. 14(1)(a), (b) & (c).
- ²³ UGANDA BUREAU OF STATISTICS, UGANDA DEMOGRAPHIC AND HEALTH SURVEY 2006 tbl. 40.6 (2007), *available at* <http://www.measuredhs.com/pubs/pdf/FR194/FR194.pdf> [hereinafter 2006 UDHS].
- ²⁴ UGANDA BUREAU OF STATISTICS, UGANDA DEMOGRAPHIC AND HEALTH SURVEY 2011 77 & 89 (2007), *available at* <http://www.measuredhs.com/pubs/pdf/FR194/FR194.pdf> [hereinafter 2011 UDHS].
- ²⁵ MINISTRY OF HEALTH, UGANDA SERVICE PROVISION ASSESSMENT SURVEY 2007 88 (2008) [hereinafter PROVISION ASSESSMENT].
- ²⁶ 2011 UDHS, *supra* note 24 at 79.
- ²⁷ *Id.* at 79

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- ²⁸ 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].
- ²⁹ Further, contraceptive-use rate for women is 46% in urban areas compared to 27% in rural areas; 48% of married women in Kampala compared to only 8% in Karamoja; and 46% of women in the highest wealth quintile compared to 15% in the lowest wealth quintile, 2011 UDHS, *supra* note 24 at 81.
- ³⁰ PROVISION ASSESSMENT, *supra* note 25 at 92.
- ³¹ 2011 UDHS, *supra* note 24 at 93-96.
- ³² PROVISION ASSESSMENT, *supra* note 25 at 97.
- ³³ UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA, *supra* note 28 at 22.
- ³⁴ CENTER FOR REPRODUCTIVE RIGHTS ET AL., THE STAKES ARE HIGH: THE TRAGIC IMPACT OF UNSAFE ABORTION AND INADEQUATE ACCESS TO CONTRACEPTION IN UGANDA 44 (2013) [hereinafter STAKES ARE HIGH].
- ³⁵ *Id.*
- ³⁶ *Id.* at 45.
- ³⁷ 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*].
- ³⁸ STAKES ARE HIGH, *supra* note 34, at 54.
- ³⁹ UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA, *supra* note 28 at 22.
- ⁴⁰ See STAKES ARE HIGH, *supra* note 34, at 42-43.
- ⁴¹ See *Id.* at 42-43.
- ⁴² See *Id.* at 48.
- ⁴³ *Id.* at 48.
- ⁴⁴ *Id.* at 50.
- ⁴⁵ CENTER FOR REPRODUCTIVE RIGHTS, BRIEFING PAPER: GOVERNMENTS WORLDWIDE PUT EMERGENCY CONTRACEPTION INTO WOMEN'S HANDS: A GLOBAL REVIEW OF LAWS AND POLICIES 1 (2004).
- ⁴⁶ 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].
- ⁴⁷ *Id.* at 5.
- ⁴⁸ REPUBLIC OF UGANDA, MINISTRY OF HEALTH, UGANDA SERVICE PROVISION ASSESSMENT SURVEY 2007 19, tbls. A-5.2.1, A.5.2.2. (2008).
- ⁴⁹ 2011 UDHS, *supra* note 24 at 78.
- ⁵⁰ See, Byamugisha, *supra* note 46, at 22-23.
- ⁵¹ *Id.* at 56-57.
- ⁵² *Id.* at 48.
- ⁵³ See *Id.*
- ⁵⁴ See WORLD HEALTH ORGANIZATION (WHO), FACT SHEET: EMERGENCY CONTRACEPTION, NO. 244 (2012), available at <http://www.who.int/mediacentre/factsheets/fs244/en/>.
- ⁵⁵ Friday Okonofua, *Abortion and Maternal Mortality in the Developing World*, 28(11) J Obstet Gynaecol Can 974, 975 (2006), available at http://www.sogc.org/jogc/abstracts/full/200611_WomensHealth_1.pdf.
- ⁵⁶ Maputo Protocol, *supra* note 2, art. 14(2)(c).
- ⁵⁷ Stephen Malinga et al., *Maternal Morbidity and Mortality in Uganda* 5 (2008) (submission to ALL-PARTY PARLIAMENTARY GROUP ON POPULATION, DEVELOPMENT & REPRODUCTIVE HEALTH-U.K.) [hereinafter Malinga, *Maternal Morbidity*]; See also statement made by Dr Collins Tusingwire, the Ministry of Health Assistant Commissioner for Reproductive Health, acknowledging that “abortion accounts for a third of maternal deaths”. Catherine Mwesigwa Kizza, *Unsafe abortions kill 1,500 women a year in Uganda*, NEW VISION, Oct. 22, 2013, <http://www.newvision.co.ug/news/648666-unsafe-abortions-kill-1-500-women-a-year-in-uganda.html> (last visited Sept. 25, 2014).
- ⁵⁸ CONSTITUTION OF THE REPUBLIC OF UGANDA (1995), art. 22(2); Penal Code Act, Cap. 120, sec. 244 (Uganda).
- ⁵⁹ In the case—*Rex v. Bourne*—the court held that an abortion would not be “unlawful” if done “in good faith for the purpose only of preserving the life of the mother” and that “if the doctor is of the opinion, on reasonable grounds and with adequate knowledge, that the probable consequence of the continuance of the pregnancy will be to make the woman a physical or mental wreck,” then it constitutes acting in preservation of the life of the woman. See *Rex v. Bourne*, [1939] 1 K.B. 687
- ⁶⁰ MINISTRY OF HEALTH (UGANDA), THE NATIONAL POLICY GUIDELINES AND SERVICE STANDARDS FOR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS 4.13 (2006) [hereinafter NATIONAL POLICY GUIDELINES].

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- ⁶¹ CENTER FOR REPRODUCTIVE RIGHTS, BRIEFING PAPER: A TECHNICAL GUIDE TO UNDERSTANDING THE LEGAL AND POLICY FRAMEWORK ON TERMINATION OF PREGNANCY IN UGANDA 6 (2012).
- ⁶² *Id.* at 29.
- ⁶³ STAKES ARE HIGH, *supra* note 34, at 32.
- ⁶⁴ *Id.* at 32.
- ⁶⁵ *Id.* at 24.
- ⁶⁶ *Benefits of Meeting Needs*, *supra* note 37 at 5; See UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA, *supra* note 28 at 4, 6 & 25.
- ⁶⁷ UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA, *supra* note 28 at 5, 6 & 17.
- ⁶⁸ *Id.* at 5.
- ⁶⁹ ELENA PRADA, ET AL., ABORTION AND POST-ABORTION CARE IN UGANDA: A REPORT FROM HEALTHCARE PROFESSIONALS AND HEALTH FACILITIES OCCASIONAL REPORT No. 17 5 (2005), *available at* <http://www.guttmacher.org/pubs/2005/05/28/or17.pdf> [hereinafter ABORTION & POST-ABORTION CARE IN UGANDA].
- ⁷⁰ *Benefits of Meeting Needs*, *supra* note 37 at 3.
- ⁷¹ ABORTION & POST-ABORTION CARE IN UGANDA, *supra* note 69; See UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA, *supra* note 28 at 5.
- ⁷² *Benefits of Meeting Needs*, *supra* note 37 at 3.
- ⁷³ ABORTION & POST-ABORTION CARE IN UGANDA, *supra* note 69.
- ⁷⁴ UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA, *supra* note 28 at 4.
- ⁷⁵ ABORTION & POST-ABORTION CARE IN UGANDA, *supra* note 69 at 6.
- ⁷⁶ Guttmacher Institute, Abortion in Uganda (2013), <http://www.guttmacher.org/pubs/FB-Abortion-in-Uganda.html>.
- ⁷⁷ STAKES ARE HIGH, *supra* note 34, at 20.
- ⁷⁸ *Id.* at 20.
- ⁷⁹ Central Intelligence Agency, *The World Fact Book: Uganda*, <https://www.cia.gov/library/publications/the-world-factbook/geos/ug.html> (last visited Sept. 25, 2014).
- ⁸⁰ STAKES ARE HIGH, *supra* note 34, at 21.
- ⁸¹ *Id.*
- ⁸² *Id.* at 26.
- ⁸³ Mallinga, *Maternal Morbidity*, *supra* note 57 at 5.
- ⁸⁴ CEDAW Committee, *Concluding Observations: Uganda*, para. 35 (2010), U.N. Doc. CEDAW/C/UGA/CO/7.
- ⁸⁵ *Id.*
- ⁸⁶ *Id.* para. 147.
- ⁸⁷ *Id.* para. 148.
- ⁸⁸ NATIONAL POLICY GUIDELINES, *supra* note 60 at 45-47.
- ⁸⁹ *Id.* at 46 (2006).
- ⁹⁰ *Id.* at 48 (2006).
- ⁹¹ Vacuum aspiration is a surgical method using an electric pump or manual aspirator to create a vacuum, and the uterine contents and lining are removed through the cervix using a cannula. It is the safest method for first-trimester abortion, and is also medically indicated for use in spontaneous abortion, menstrual regulation, treatment of incomplete abortion, and endometrial biopsy. TRACI BAIRD & SUSAN K. FLINN, MVA MANUAL VACUUM ASPIRATION: EXPANDING WOMEN'S ACCESS TO SAFE ABORTION SERVICES 3 (2001), *available at* <http://www.ipas.org/~media/Files/Ipas%20Publications/IndMono.ashx>.
- ⁹² Dilation and curettage (D & C) is a surgical method which involves the dilation of the cervix followed by the removal of part or all of the lining or contents of the uterus. It is used primarily for the diagnosis of gynecological conditions, and less frequently to perform first-trimester abortions. See NYU Langone Medical Center, *Dilation and Curettage* (2013), *available at* <http://www.med.nyu.edu/patientcare/library/article.html?ChunkIID=14802> (last visited Apr. 18, 2013).
- ⁹³ PROVISION ASSESSMENT, *supra* note 25 at 132.
- ⁹⁴ *Id.* at 136, tbl. 6.13 (2008).
- ⁹⁵ ABORTION & POST-ABORTION CARE IN UGANDA, *supra* note 69 at 17.
- ⁹⁶ See *Id.* at 7.
- ⁹⁷ *Id.*
- ⁹⁸ Els De Temmerman & Irene Nabusoba, *Abortion Kills 1,200 Women Every Year*, NEW VISION, Sept. 14, 2007, <http://www.newvision.co.ug/PA/9/183/586728> (last visited Sept. 25, 2014).
- ⁹⁹ *Ug v Dr. Hassan Nawabul & Anor* (Crim. Case 562/08), as cited in DR. MARIA NASSALI, LEGAL ASSESSMENT: UGANDA, A LEGAL AND POLITICAL ANALYSIS OF ABORTION IN UGANDA 14 & 19 (2010).

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- ¹⁰⁰ ABORTION & POST-ABORTION CARE IN UGANDA, *supra* note 69 at 6.
- ¹⁰¹ STAKES ARE HIGH, *supra* note 34, at 17.
- ¹⁰² *Id.*
- ¹⁰³ *Id.* at 16.
- ¹⁰⁴ WHO AT AL., TRENDS IN MATERNAL MORTALITY: 1990-2013, 4 (2014), *available at* http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf [hereinafter TRENDS IN MATERNAL MORTALITY].
- ¹⁰⁵ Committee on Economic, Social, and Cultural Rights (CESCR Committee), *General Comment 14, The Right to the Highest Attainable Standard of Health*, para. 21 (22ND Sess., 2000) U.N. Doc. HRI/GEN /1/Rev.5 (2001). *See, e.g., CEDAW Committee Concluding Observations: Belize*, para. 56 (1999), U.N. Doc. A/54/38; *Colombia*, para. 393 (1999), U.N. Doc A/54/38; *Dominican Republic*, para. 337 (1998) U.N. Doc A/53/38; *Madagascar* para. 244 (1994) U.N. Doc A/49/38.
- ¹⁰⁶ CEDAW Committee, *Concluding Observations: Uganda*, para. 35 (2010), U.N. Doc. CEDAW/C/UGA/CO/7.
- ¹⁰⁷ *Id.* para. 36.
- ¹⁰⁸ UGANDA MINISTRY OF FINANCE, PLANNING AND ECONOMIC DEVELOPMENT, MILLENNIUM DEVELOPMENT GOALS REPORT FOR UGANDA 2013 24 (2013) [hereinafter MDG REPORT].
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