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Report on Uganda's Compliance with its Human Rights Obligations in the Area of Women's Reproductive and Sexual Health

Submitted by:

Center for Reproductive Rights

and

Center for Health, Human Rights and Development

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Center for Reproductive Rights
Morningside Office Park
1st Floor, Wing A
Ngong Road
P.O. Box 48136-00100
Nairobi, Kenya

Center for Health, Human Rights & Development
Plot 833, Old Kiira Road
Ntinda Kiwatule
P.O. Box 16617
Wandegeya
Kampala, Uganda

1. In accordance with Human Rights Council Resolution 5/1 of June 18, 2007, the Center for Reproductive Rights (CRR), a global non-governmental organization that uses the law to advance reproductive freedom as a fundamental human right, and the Center for Health, Human Rights and Development (CEHURD), a not-for-profit research and advocacy organization that ensures that laws and policies are used as principal tools for the promotion and protection of health and human rights of populations in Uganda and in the East African region, makes this submission intended to supplement the report of the government of Uganda, scheduled for review by the Human Rights Council during its 26th session.[1]

I. INTRODUCTION

2. In accordance with international and regional human rights treaties, which Uganda has ratified,[2] the government is obligated to ensure and protect the sexual and reproductive rights of women and girls. Despite these protections in however, women and girls continue to lack access to sexual and reproductive health information and services in violation of their right, inter alia, to life, health, equality and non-discrimination, dignity and freedom from cruel, inhuman and degrading treatment. This submission highlights the following issue of concern: inadequate access to quality maternal healthcare; lack of access to safe abortion and post-abortion care services; lack of access to contraceptive information and services; physical and sexual violence against women and girls; and discrimination against women living with HIV/AIDS.

II. KEY ISSUES

A) Rights to Reproductive Health Information and Services

i. Access to maternal healthcare

3. Maternal death is defined as any death that occurs during pregnancy, childbirth, or within 42 days of birth or termination of pregnancy or its management.[3] Treaty monitoring bodies have affirmed that states' failure to reduce maternal deaths violates a number of rights including the

[1] *See* United Nations Human Rights Council, Human Rights Council Universal Periodic Review (Second Cycle), *available at* http://www.ohchr.org/Documents/HRBodies/UPR/UPRFullCycleCalendar2nd.doc.
[2] *See, e.g.,* Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), *adopted* Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., U.N. Doc. A/34/46, 1249 U.N.T.S. 13 (ratified by Uganda Jul. 22, 1985); International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (ascension by Uganda Jun. 21, 1995); International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 2, 5 (ascension by Uganda Jan. 21, 1987); African (Banjul) Charter on Human and Peoples' Rights, June 27, 1981, O.A.U. Doc. CAB/LEG/67/3, rev. 5, 21 I.L.M. 58 (1982) (ratified by Uganda Mar. 27, 1986).
[3] WORLD HEALTH ORGANIZATION (WHO) ET AL., TRENDS IN MATERNAL MORTALITY 1990-2013, ESTIMATES BY WHO, UNICEF, UNFPA, THE WORLD BANK AND THE UNITED NATIONS, AND THE UNITED NATIONS POPULATION DIVISION 4 (2014), *available at* http://apps.who.int/iris/bitstream/10665/112682/2/9789241507226_eng.pdf?ua=1 [hereinafter WHO, TRENDS IN MATERNAL MORTALITY 1990-2013].

rights to health and life,[4] and have asked the government of Uganda to take concrete steps to address the high maternal mortality level.[5] During the previous Universal Periodic Review (UPR) of Uganda, the government accepted recommendations to continue to work towards reducing the high maternal mortality.[6] The Committee on Economic, Social and Cultural Rights (ESCR Committee), during its review of Uganda in 2015, also expressed concern regarding the high rate of maternal mortality, and recommended that the government intensify its efforts to reduce the rate including by sufficiently equipping facilities to provide antenatal, delivery and postnatal care.[7]

4. Despite these recommendations, however, maternal mortality in Uganda remains high: according to the World Health Organization (WHO), the maternal mortality rate is 343 maternal deaths per 100,000 live births.[8] Although this a decline from the 2010 rate of 420 live births per 100,000 deaths, Uganda had not achieved the Millennium Development Goal of reducing the maternal mortality by three quarters by 2015.[9] Further, for every maternal death in Uganda, approximately six women will suffer severe morbidities.[10] As the latest Demographic Health Survey (UDHS 2011) shows, only 48%[11] of pregnant women and girls attend four or more antenatal care visits as recommended by the WHO.[12] Only 57% of the deliveries were at a health care facility.[13] There is also wide disparity in access to skilled delivery care based on geographical location: 89% of women and girls who live in urban areas delivered in health care facilities while the rate is only 52% for those living in rural areas.[14] In addition, 64% women did not receive any postnatal care, even though a large proportion of maternal deaths occur during postpartum period.[15]

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[4] Committee on Economic, Social and Cultural Rights (ESCR Committee), *General Comment No. 14: The right to the highest attainable standard of health (Art. 12)*, (22nd Sess., 2000), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 91, para. 52, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *Gen. Comment No. 14]*; *See, e.g.*, CEDAW Committee, *Concluding Observations*: *Belize*, para. 56, U.N. Doc. A/54/38/Rev.1 (1999); *Colombia*, para. 393 (1999), U.N. Doc. A/54/38/Rev.1; *Dominican Republic*, para. 337, U.N. Doc. A/53/38 (1998).

[5] *See, e.g.*, ESCR Committee, *Concluding Observations on the Initial Report of Uganda*, para. 33, U.N. Doc. E/C.12/UGA/CO/1 (June 24, 2015) [hereinafter *CESCR Concluding Observations: Uganda*]; CEDAW Committee, *Concluding Observations: Uganda*, para. 36, U.N. Doc. CEDAW/C/UGA/CO/7 (Oct 22, 2010).

[6] Human Rights Council (HRC), *Universal Periodic Review: Uganda*, paras. 111.86, 111.90, & 111.91, (2011), U.N. Doc. A/HRC/19/16 [hereinafter HRC *Report: Uganda* 2011].

[7] *CESCR Concluding Observations: Uganda*, *supra* note 5, para. 33.

[8] WHO ET AL., TRENDS IN MATERNAL MORTALITY: 1990 TO 2013, *supra* note 3, at 76.

[9] *Id.*

[10] Partnership for Maternal, Newborn & Child Health, *Maternal and Child Health: Uganda*, 1 (2007), *available at* http://www.who.int/pmnch/media/membernews/2011/ugandabackgroundpaper.pdf.

[11] UGANDA BUREAU OF STATISTICS, UGANDA DEMOGRAPHIC AND HEALTH SURVEY 2011 107 (2012), *available at* https://dhsprogram.com/pubs/pdf/FR264/FR264.pdf [hereinafter 2011 UDHS].

[12] *Id.*

[13] *Id.* at 111.

[14] *Id.*

[15] *Id.* at 114.

5. The Ministry of Health has attributed difficulties in accessing maternal health services to several factors, including a lack of human resources, medicines and supplies, weak infrastructure and behavioral issues such as delays in seeking care and weak internal communications protocols at health care facilities.[16] Even though public health care facilities provide maternal health services free of charge, they often require that women purchase supplies from outside pharmacies when there is stock-out.[17] This discourages women from seeking delivery care from heath care facilities, since they are concerned that they have to travel to the health facility only to find out that there is no supplies. This in turn creates disparities in access based on a women's level of income and geographical location.[18]

6. In Uganda's previous UPR, the Human Rights Council recommended that the government raise the health budget to 15% in line with the Abuja Declaration in order to increase access to sexual and reproductive health services.[19] However, 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 and this actually decreased to 8.4% in the 2014-2015 budget.[20] Instead of improving, the budget allocation for health has decreased to 7% of the total budget for 2015-2016 fiscal year.[21] If the government is to achieve the goals it has committed to under the Sustainable Development Goals, including reducing the MMR to less than 70 deaths per 100,000 live births by 2030, [22] it needs to intensify its efforts of making maternal health care services more accessible including by allocating adequate resources.

ii. Lack of access to safe abortion services and post-abortion care

7. The United Nations Special Rapporteur on the Right to Health has confirmed that the criminalization of abortion and other reproductive health services violates the right to health by imposing barriers that interfere with accessibility to safe health care services and with individual decision-making in health-related matters.[23] Such criminalization also perpetuates

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[16] GOVERNMENT OF UGANDA, MINISTRY OF HEALTH, HEALTH SECTOR STRATEGIC PLAN III 11(2010), *available at* http://www.health.go.ug/docs/HSSP_III_2010.pdf.

[17] Elizabeth Leahy Madsen, et. al., Population Action International, Maternal Health Supplies in Uganda 5 (2010), *available at* http://www.who.int/pmnch/activities/commodities/2010_maternal_health_uganda.pdf?ua=1.

[18] *See e.g.*, 2011 UDHS, *supra* note 11.

[19] HRC *Report: Uganda 2011*, *supra* note 6, para. 112.41.

[20] The Republic of Uganda, Ministry of Finance, Planning and Economic Development, NATIONAL BUDGET FRAMEWORK PAPER 64 (2014), *available at* http://csbag.org/wp-content/uploads/2015/10/National-Budget-Framework-Paper-FY-2014-15.pdf.

[21] The Republic of Uganda, Ministry of Finance, Planning and Economic Development, NATIONAL BUDGET FRAMEWORK PAPER 39 (2015), *available at* http://library.health.go.ug/download/file/fid/580721.

[22] United Nations (UN), SUSTAINABLE DEVELOPMENT GOALS, GOAL 3 TARGETS (2015), *available at* http://www.un.org/sustainabledevelopment/health/.

[23] Special Rapporteur on the rights of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Interim rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, transmitted by Note of the Secretary-General*, paras. 21 & 25,

gender stereotypes, and marginalizes and disempowers women by forcing them to choose between making personal decisions about their health and well-being or facing criminal liabilities.[24] Similarly, several human rights bodies have found that both restrictive abortion laws and the failure to ensure access to abortion when it is legal are incompatible with international human rights obligations, amounting to violations of the rights to life and health, the right to be free from cruel, inhuman and degrading treatment, and the right to be free from discrimination.[25] The African Charters' Protocol on the Rights of Women in Africa (Maputo Protocol) also explicitly requires states to authorize medical abortion in cases of rape, incest and where the pregnancy threatens the life or health of the women or the fetus.[26] While the Ugandan government has ratified the Maputo Protocol and has repeatedly recognized unsafe abortion as a leading cause of maternal mortality and morbidity, [27] the government has entered a reservation on this article which would have expanded access to safe abortion.[28]

8. Still, lack of access to safe abortion services and post-abortion care is a severe problem in Uganda. This is, in part, due to the ambiguity and misinformation surrounding the legality of abortion and post-abortion services. Under Ugandan law, abortion is permitted only to preserve

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U.N. Doc. A/66/254 (2011) (citing WHO, SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 86 (Geneva, 2003)).

[24] *Id.*, at 16, 21 & 25 (citing WHO, SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 86 (Geneva, 2003)).

[25] Report of the United Nations High Commissioner for Human Rights, *Practices for Adopting a Human Rights-Based Approach to Eliminate Preventable Maternal Mortality and Human Rights,* para. 26, U.N. Doc. A/HRC/18/27 (2011); S*ee* Human Rights Committee, *Concluding Observations*: *Argentina,* para. 14, CCPR/CO/70/ARG (2000); *Peru,* para. 20, U.N. Doc. CCPR/CO/70/PER (2000); *Morocco,* para. 29, U.N. Doc. CCPR/CO/82/MAR (2004); *See also* 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, at 358, para. 31(c), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008); Human Rights Committee, *Concluding Observations*: *Sri Lanka,* para. 12, U.N. Doc. CCPR/CO/79/LKA (2003); Committee Against Torture (CAT Committee), *Concluding Observations*: *Chile,* para. 6(j), U.N. Doc. CAT/C/CR/32/5 (2004); CEDAW Committee, *Concluding Observations: Chile,* para. 19, U.N. Doc. CEDAW/C/CHI/CO/4 (2006).

[26] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa art. 14 (2) (C), *adopted* July 11, 2003, 2nd African Union Assembly, Maputo, Mozambique (*ratified* July 22, 2010).

[27] *See* 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, *at* http://www.newvision.co.ug/news/648666-unsafe-abortions-kill-1-500-women-a-year-in-uganda.html (last visited Mar. 16, 2016); statement made by Sara Opendi, Minister of State for Health in charge of Primary Health: Ronald Musoke, *Ugandan women needlessly dying from unsafe abortion*, THE INDEPENDENT, Feb. 18, 2014, http://www.independent.co.ug/news/news/8720-ugandan-women-needlessly-dying-from-unsafe-abortion (last visited Mar. 16, 2016): CEHURD, *Launching the standards and guidelines on unsafe abortions to confront the public health crisis in Uganda*, June 5, 2015, *available at* http://www.cehurd.org/2015/06/launching-the-standards-and-guidelines-on-unsafe-abortions-to-confront-the-public-health-crisis-in-uganda/ (last visited Mar. 16, 2016) [hereinafter CEHURD *Launching Standards and Guidelines on unsafe abortions* 2015].

[28] African Commission on Human and Peoples' Rights, *Concluding Observations and Recommendations on the 5th Periodic State Report of the Republic of Uganda (2010-2012)* para. 77 (2015), *available at* http://www.achpr.org/files/sessions/57th/conc-obs/5-2010-2012/concluding_observations_5th_state_report_uganda.pdf.

the life, mental and physical health of the pregnant woman.[29] However, the Ministry of Health's National Guidelines and Services Standards for Sexual and Reproductive Health and Rights expands grounds for permitting legal abortion to include cases such as sexual violence and incest and outlines comprehensive abortion and post-abortion care standards.[30] The narrow interpretation 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 officers, the judiciary, and regulators.[31]

9. As a result, annually, approximately 400,000 unsafe abortions are performed in Uganda, with 90,000 women and girls suffering severe complications.[32] Approximately 1,500 of women and girls die annually due to unsafe abortion amounting to 26% of Uganda's maternal mortality.[33] It is further estimated that 65,000 women who experience complications from unsafe abortions do not receive any treatment.[34] Often, low-income women and women living in rural areas who encounter barriers to accessing skilled providers, "resort to abortions performed by untrained providers using unsafe methods or attempt to self-induce an abortion."[35] For instance, one study found that 68-75% of rural women who had abortions have experienced complications while only 17% urban women that accessed the service from a doctor suffered complications.[36]

10. The ambiguity in the law further deters health care professionals from providing safe abortion services. As documented in a fact-finding report published by the Center, *The Stakes Are High*, most doctors and other trained providers mistakenly believe that there is a complete prohibition on abortion.[37] 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

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[29] CEHURD *Launching Standards and Guidelines on unsafe abortions* 2015 *supra* note 27; *See* also CENTER FOR REPRODUCTIVE RIGHTS, BRIEFING PAPER: A TECHNICAL GUIDE TO UNDERSTANDING THE LEGAL AND POLICY FRAMEWORK ON TERMINATION OF PREGNANCY IN UGANDA 11-27 (2012)), *available at* http://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/crr_UgandaBriefingPaper_v5.pdf [hereinafter CRR BRIEFING PAPER 2012].

[30] REPRODUCTIVE HEALTH DIVISION, MINISTRY OF HEALTH, NATIONAL POLICY GUIDELINES AND SERVICE STANDARDS FOR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS 4, 13 (2006) [hereinafter NATIONAL SEXUAL AND REPRODUCTIVE HEALTH GUIDELINES].

[31] CRR BRIEFING PAPER 2012, *supra* note 29 at 6.

[32] MINISTRY OF HEALTH, REDUCING MATERNAL MORBIDITY AND MORTALITY FROM UNSAFE ABORTION IN UGANDA: STANDARDS AND GUIDELINES 1 (2015) [hereinafter MOH REDUCING MMR FROM IN UGANDA S&GS 2015].

[33] *Id.*

[34] CENTER FOR REPRODUCTIVE RIGHTS ET AL., THE STAKES ARE HIGH: THE TRAGIC IMPACT OF UNSAFE ABORTION AND INADEQUATE ACCESS TO CONTRACEPTION IN UGANDA 7 (2013) [hereinafter STAKES ARE HIGH].

[35] Guttmacher Institute, Fact Sheet: Abortion in Uganda (2013), *available at* http://www.guttmacher.org/pubs/FB-Abortion-in-Uganda.pdf.

[36] Guttmacher Institute, In Brief: Unintended Pregnancy and Abortion in Uganda 3 (2013), *available at* http://www.guttmacher.org/pubs/IB-Unintended-Pregnancy-Uganda.pdf [hereinafter Brief: Unintended Pregnancy and Abortion in Uganda 2013].

[37] STAKES ARE HIGH, *supra* note 34, at 8.

Penal Code.[38] 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.[39] 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."[40]

11. Recently, the government of Uganda took some important steps to improve access to safe abortion services. For instance, in June 2015, the Ministry of Health issued the *"Standards & Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Uganda,"* (Standards and Guidelines) with the aim of providing "practical and standardized information to various stakeholders from a range of sectors that will help reduce morbidity and mortality due to unsafe abortion."[41] The Standards and Guidelines provide a guidance on the minimum standards of care required to be met by all facilities and healthcare workers and the provision of abortion and post-abortion care in line with Uganda's laws.[42] The Standards and Guidelines cover three issues: prevention of unsafe abortion through reducing abortion-related stigma and preventing unintended pregnancies; management of unintended and risky pregnancies; and post-abortion care.[43] If implemented effectively the Standard and Guidelines are expected to improve the quality of medical services by providing clear guidance on the provision of safe abortion services and the management of unsafe abortion as well as educating health workers and policy makers.[44] However, it is concerning that the implementation of the Standards and Guidelines have been delayed.

12. Further, in its Annual Health Sector Performance Report for 2014- 2015, the Ministry of Health reported a decline in maternal deaths due to complications from unsafe abortions: the report documented a decrease from 15% of all maternal deaths in 2011-2012 to 3% of all maternal deaths in 2014-2015.[45] However, the data cited in the Standards and Guidelines estimates that 26% of maternal deaths are due to unsafe abortions.[46]

Post-Abortion Care

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[38] *Id.*

[39] *Id.*, at 32.

[40] *Id.*

[41] MOH REDUCING MMR FROM IN UGANDA S&GS 2015 *supra* note 32, at xiii-xiv.

[42] *Id.*

[43] *See, generally, Id.*, at xiii, 4, and 5.

[44] *See, generally,* Id., at xiii-xiv.

[45] THE REPUBLIC OF UGANDA MINISTRY OF HEALTH, ANNUAL HEALTH SECTOR PERFORMANCE REPORT: FINANCIAL YEAR 2014/2015 5, *available at* http://www.health.go.ug/content/annual-health-sector-performance-report-financial-year-201415.

[46] MOH REDUCING MMR FROM IN UGANDA S&GS 2015 *supra* note 32, at xiii.

13. According to Uganda's National Sexual and 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."[47] The Standards and Guidelines also provides that PAC "should be provided by trained and skilled health professionals in a health facility that meets minimum standards."[48] 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 a small percentage of the health facilities that offer delivery services.[49] A study published in 2014 revealed that Manual Vacuum Aspiration (MVA)—the preferred method for PAC for first trimester abortions—was not available in all health care facilities and providers were not trained to use the equipment.[50] 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.[51]

14. Lack of access to qualified doctors for abortion services is exacerbated by the high cost and limited availability of adequate PAC. Research has indicated that, due to the prevailing stigma against abortion in Uganda, healthcare providers in some instances mistreat or abuse women seeking PAC.[52] Surveys have also shown that most healthcare providers acknowledge their preference to treat complications of miscarriage rather than complications of induced abortions.[53] Given this stigma, a substantial number of women who require post-abortion care may be reluctant to seek it out. Post-abortion care also has an economic implication: each abortion costs an average of U.S. $130 per patient and an estimated additional U.S. $177 in societal costs, with almost half of the health system cost being paid by women, many of whom subsist on an income of less than U.S. $1 per day.[54]

15. As a result, according to one study, health professionals estimate that only 51% of low-income rural women who suffer abortion complications can access medical assistance as compared to 83% of those with higher income that live in urban areas.[55] Most often, women do not seek medical treatment for abortions or related complications due to various reasons including lack of funds, distance from fully equipped facilities and fear of negative reactions and mistreatment

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[47] NATIONAL SEXUAL AND REPRODUCTIVE HEALTH GUIDELINES, *supra* note 30, at 45-47.
[48] *Id.*
[49] *See, e.g.*, MINISTRY OF HEALTH, UGANDA SERVICE PROVISION ASSESSMENT SURVEY 2007 132 (2008) [hereinafter PROVISION ASSESSMENT].
[50] Mandira Paul et.al, *Barriers and facilitators in the provision of post-abortion care at district level in central Uganda—a qualitative study focusing on task sharing between physicians and midwives*, 14 BMC HEALTH SERVICES RESEARCH 28, 6 (2014) [hereinafter *Barriers and facilitators*].
[51] *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).
[52] Brief: Unintended Pregnancy and Abortion in Uganda 2013, *supra* note 36, at 4.
[53] *Id.; See* also *Barriers and facilitators, supra* note 50.
[54] Brief: Unintended Pregnancy and Abortion in Uganda 2013, *supra* note 36, at 4-5
[55] ELENA PRADA, ET AL., ABORTION AND POST-ABORTION CARE IN UGANDA: A REPORT FROM HEALTHCARE PROFESSIONALS AND HEALTH FACILITIES, OCCASIONAL REPORT NO. 17 7 (2005) [Hereinafter ABORTION AND POST-ABORTION CARE IN UGANDA].

from health care providers.[56] 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."[57] 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.[58] 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 but it was already too late and she ultimately died.[59]

iii. Lack of access to contraceptive information and services

16. Access to family planning services and information plays an integral role in protecting women's and girls' rights to life and health. Without access to contraceptive services, women and girls may experience unwanted pregnancies, possibly resulting in death or illness due to lack of adequate healthcare, or they may seek out unsafe abortions that result in injury or death.[60] Despite the government's efforts to improve access to family planning information and services, according to the 2011 Uganda Demographic and Health Survey (UDHS), the unmet need for family planning for married women in Uganda stood at 34%.[61] In addition, while the use of modern contraceptives increased from 15% in 2006to 21% in 2011,[62] a vast number of women and girls still do not have access to contraceptive information and services. Indeed, more than three quarters of Ugandan women still do not use modern contraception, and four in ten pregnancies are unintended.[63] Further, the use of, and access to, contraception among women also varies depending on geographical location, level of education and income level. According to the 2011 UDHS, 46% of married women living in urban areas used some method of contraception, as opposed to only 27% of married women located in rural areas.[64] In addition, 44% of married women with a secondary level or more of education used contraceptives as compared to only 18% of those with no education.[65] Finally, 46% of married

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[56] *Id.*, at 6.
[57] STAKES ARE HIGH, *supra* note 34, at 17.
[58] *Id.*
[59] *Id.*
[60] STAKES ARE HIGH *supra* note 34, at 7.
[61] UGANDA BUREAU OF STATISTICS, UGANDA DEMOGRAPHIC AND HEALTH SURVEY 2006 69 (2007) *available at* http://dhsprogram.com/pubs/pdf/FR194/FR194.pdf; 2011 UDHS, *supra* note 11, at 80.
[62] *Id.*, at 80.
[63] Guttmacher Institute, Fact Sheet: Contraception and Unintended Pregnancy in Uganda 1 (2013), *available at* https://www.guttmacher.org/pubs/FB-Contraception-and-unintended-pregnancy-in-Uganda.pdf [hereinafter Contraception and Unintended Pregnancy in Uganda 2013].
[64] 2011 UDHS, *supra* note 11, at 81.
[65] *Id.*

women from the highest wealth quintile used some form of contraception as compared to only 15% of women from the lowest wealth quintile.[66]

17. This low rate of contraceptive use and high unmet rate can be attributed to the numerous barriers women and girls encounter in trying to access family planning services, including user fees, unavailability of a preferred contraceptive method,[67] and insufficient counseling services.[68] Other factors, such as the fear of side effects,[69] the inconvenience of using modern contraceptives, partners' opposition to contraceptive use and the belief that contraceptives are prohibited by religion, inhibit women from using contraceptives.[70] One study revealed that men's misconceptions regarding contraceptives, such as that they cause health problems, influence women's use of the methods.[71] A 2014 study revealed that distance of health care facilities also influence women and girls' decisions to use modern contraceptives.[72]

18. The Center's 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.[73] However, immediately after she stopped using an oral contraceptive, she conceived and ultimately underwent a clandestine abortion.[74] 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."[75]

19. Other women reported feeling hesitant to obtain contraceptives because using or even discussing contraceptives with their spouses or male partners could imply infidelity.[76] As one

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[66] *Id.*

[67] PROVISION ASSESSMENT, *supra* note 49, at 97-99.

[68] 2011 UDHS, *supra* note 11, at 95-96.

[69] John B Asiimwe et al., *Factors Associated with Modern Contraceptive Use among Young and older Women in Uganda; A Comparative Analysis*, 14 BMC PUB. HEALTH 926 (2014), *available at* http://www.biomedcentral.com/1471-2458/14/926 [hereinafter *Factors Associated with Contraception Use*]; GUTTMACHER INSTITUTE, UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA 22 (2006), *available at* https://www.guttmacher.org/pubs/2006/11/27/UgandaUPIA.pdf [hereinafter 2006 REPORT: UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA].

[70] 2006 REPORT: UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA, *supra* note 69.

[71] Contraception and Unintended Pregnancy in Uganda 2013, *supra* note 63.

[72] *Factors Associated with Contraception Use*, *supra* note 69, at 1, 4, and 8.

[73] STAKES ARE HIGH, *supra* note 34, at 44.

[74] *Id.*

[75] *Id.* at 45.

[76] 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.

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."[77] 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.[78] 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.[79] She noted that her life improved greatly once she had access to family planning services.[80]

Lack of Access to Emergency Contraception

20. Emergency contraception (EC) plays a vital role in preventing unplanned and unwanted pregnancies and is a critical component of care for survivors of sexual abuse.[81] In Uganda, one type of EC is registered and included in the Essential Medicines and Health Supplies List.[82] However, it is available by prescription only[83] which can create barriers to women and girls' access to EC since the pill needs to be taken within 72 hours of unprotected sex.[84] In addition, the 2011 UDHS reported that only 31% of women in Uganda know about EC.[85]

21. The lack of knowledge and usage of EC can be attributed to a number of factors, including, insufficient training on the use of EC,[86] as well as common misperceptions about EC including the notion that it will inhibit future fertility, cause extreme side effects,[87] and encourage sexual promiscuity.[88] However, these perceptions are unfounded: as the WHO has noted, side-effects of EC are uncommon and generally mild and do not affect fertility.[89] Due to the low level of

[77] STAKES ARE HIGH, *supra* note 34, at 54.
[78] 2006 REPORT: UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA, *supra* note 69, at 22.
[79] *See* STAKES ARE HIGH, *supra* note 34, at 42-43.
[80] *See Id.*
[81] WHO, *Fact Sheet No. 244 Emergency Contraception Fact Sheet*, Feb. 2016, *available at* http://www.who.int/mediacentre/factsheets/fs244/en/ [hereinafter WHO, *Emergency Contraception*].
[82] International Consortium for Emergency Contraception (ICEC), *Counting What Counts: Tracking Access to Emergency Contraception Uganda* 1 & 2 (2015), *available at* http://www.cecinfo.org/custom-content/uploads/2015/01/ICEC_Uganda-factsheet_2015.pdf.
[83] *Id.*
[84] WHO, *Emergency Contraception*, *supra* note 81.
[85] 2011 UDHS, *supra* note 11, at 78.
[86] Josaphat K. Byamugisha et al., *Emergency Contraception and Fertility Awareness among University Students in Kampala, Uganda* 6, AFR. HLTH. SCIENCES NO. 4 198 (2006) [hereinafter Byamugisha].
[87] *Id.*
[88] *Id.*
[89] *See* WHO, *Emergency Contraception*, *supra* note 81, at xx.

usage, it was reported in 2015 that the entire stock of EC expired, leaving women, including rape survivors, without the option.[90]

Adolescents' access to sexual and reproductive health services

22. In Uganda, adolescents face tremendous hurdles that discourage them from seeking and obtaining critical sexual and reproductive health services. While the government of Uganda has made some inroads in recent years in establishing policies to address adolescent access to sexual and reproductive health services, including the Adolescent Health Policy Guidelines and Service Standards[91] and the National Minimum Healthcare Package,[92] there remains a significant gap between these policies and their successful implementation. Bridging the gap is particularly important given that nearly 1 in 4 Ugandan girls age 15-19 has already given birth or is pregnant with her first child.[93] Lack of adolescent access to sexual and reproductive health services results in a concomitant rise in maternal morbidity and mortality,[94] higher HIV/AIDS rates amongst adolescents and greater drop-out rates among school-aged girls.[95]

23. Adolescents seeking sexual and reproductive health services encounter disapproval from health workers, inadequate supplies and providers who are not trained in providing adolescent friendly services. As a result, adolescents in Uganda are left with misinformation and myths about sex. For example, a study revealed that 54% of young people think that a girl could not get pregnant when engaging in sex for the first time.[96] In addition, negative societal perceptions and stigma associated with adolescent pregnancy outside the context of marriage drive a percentage of girls in this predicament to seek unsafe abortions.[97] Twenty-four percent of young women aged 15-24 have had an abortion.[98] Since, as described above, the laws in Uganda restrict abortion and are largely ambiguous, adolescent girls seeking to terminate their pregnancies often resort to unsafe methods. As a result, nearly 30% of deaths among adolescents in Uganda can be attributed to unsafe abortions.[99]

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[90] Jina Moore, *All Of Uganda's Free Emergency Contraceptives Are About To Expire*, Buzzfeed News, June 29, 2015, http://www.buzzfeed.com/jinamoore/all-of-uganda-free-emergency-contraceptives-are-about-to-exp#.miGkj0490e.

[91] THE REPRODUCTIVE HEALTH DIVISION, MINISTRY OF HEALTH, ADOLESCENT HEALTH POLICY GUIDELINES AND SERVICES STANDARDS IN: KAMPALA UGANDA. 3RD ED. UGANDA: DEPARTMENT OF COMMUNITY HEALTH, MINISTRY OF HEALTH (2012).

[92] MINISTRY OF HEALTH, UGANDA NATIONAL HEALTH POLICY (1999).

[93] 2011 UDHS, *supra* note 11, at 57.

[94] *See, e.g.*, Rutaremwa Gideon, *Factors Associated with Adolescent Pregnancy and Fertility in Uganda: Analysis of the 2011 Demographic and Health Survey Data, Social Sciences*, 2 Science PG 7, 7-13 (2013) [hereinafter Rutaremwa].

[95] *See, e.g., Id.*

[96] Straight Talk Foundation, *Straight Talk* 2, July 2014, http://www.straighttalkfoundation.org/wp-content/uploads/2014/downloads/S-talk%20june-july.pdf

[97] *See, e.g.*, Rutaremwa, *supra* note 94, at 8.

[98] IRIN, Uganda teen pregnancies' plan under fire (July 24, 2014) *available at* http://www.irinnews.org/node/254760

[99] F. SSENGOOBA, S. NEEMA, A. MBONYE, O. SENTUBWE, AND V. ONAMA, MATERNAL HEALTH REVIEW UGANDA 18 (2004) , HSD/WP/04/03, *at* http://r4d.dfid.gov.uk/PDF/Outputs/HealthSysDev_KP/04-03_uganda.pdf

B) Sexual and Physical Violence against women and girls

24. During the 2011 UPR, Uganda accepted numerous recommendations with respect to sexual and physical violence against women and girls, several of which called on Uganda to effectively implement the Ugandan Domestic Violence Act of 2010, which was intended to, among other things, "provide for the protection and relief of victims of domestic violence."[100] Similarly, in 2015 the ESCR Committee expressed concern regarding the "inadequate implementation of the Domestic Violence Act, the delays in adopting the Sexual Offences Bill, the underreporting to the police by victims of violence, and the resorting to traditional ways of mediation that often override women's rights."[101]

25. However, marital rape is not expressly prohibited by the Domestic Violence Act. 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.[102] A 2015 publication also reported that the Minister of Gender, Labour and Social Development was called before the gender committee of the parliament to explain why the implementation of the Act has been slow.[103] Apart from trainings provided through development partners' support, the government has not "substantively invested in the implementation of the [law]" and as such, so far, the trainings have covered only 30% of Uganda.[104] Further, while the government has developed the Gender Based Violence shelter guidelines, "there is no single-state-run shelter," which is an indication that the government is not focusing on addressing the issue.[105]

26. Likewise, the proposed Sexual Offences Bill, which is still pending, 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.[106] 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

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[100] The Domestic Violence Act of 2010, 3, http://www.ulii.org/ug/legislation/act/2015/3-9.

[101] CESCR *Concluding Observations: Uganda*, *supra* note 5, at para. 25. The CESCR Committee also recommended the adopting and implementing of the "Sexual Offences Bill" as well as awareness-raising campaigns to "combat all forms of violence against women and girls and to encourage victims of violence to report such cases to the police."

[102] *See* Law Library of Congress, *Uganda: Women Judges Voice Concern over Domestic Violence*, THE LIBRARY OF CONGRESS (Jul. 8, 2013), http://www.loc.gov/lawweb/servlet/lloc_news?disp3_l205403631_text; J. Emodek et al., *Domestic Violence Cases Soar*, NEW VISION (Jun. 18, 2013), http://www.newvision.co.ug/news/644085-domestic-violence-cases-soar.html.

[103] JOSEPHINE AHIKIRE ET.AL, THE POLITICS OF PROMOTING GENDER EQUITY IN CONTEMPORARY UGANDA: CASES OF THE DOMESTIC VIOLENCE LAW AND POLICY ON UNIVERSAL PRIMARY EDUCATION 17 (2015).

[104] *Id.*, at 18.

[105] *Id.*; *See, e.g.*, GLOBAL GIVING UK, *WORI Uganda Domestic Violence Shelter*, http://www.globalgiving.co.uk/projects/wori-shelter-project/ (accessed Jan. 19, 2016).

[106] Sexual Offences Act of 2011, Bill No. 1, Part II, sec. 3, "Rape under marriage" (2011) (Uganda).

rape with a heightened standard of proof.[107] 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."[108] Similarly, the Marriage and Divorce Bill, which would have criminalized marital rape has been pending in the parliament for a long time and there has not been a recent attempt to re-table the bill.[109] Other common law jurisdictions have amended rape statutes to eliminate historical distinctions based on marital status.[110] Moreover, the Sexual Offences Bill would be improved with the inclusion of services for survivors of violence, such as a full range of "comprehensive, gender-sensitive health services," [111] including access to legal abortion, emergency contraception,[112] and post-exposure prophylaxis to protect against HIV infection.[113]

27. Due to the government's failure to effectively implement legal and policy measures, violence against women and girls remains alarmingly high. As of the 2011 UDHS, about 60% of ever-married women had experienced some form of violence (physical, sexual, emotional) by a husband or intimate partner.[114] According to recent government statistics, deaths from domestic violence in Uganda have spiked from 159 in 2010 to 181 in 2011 and falling in 2012 to 154.[115] Cultural and societal views perpetuate violence against women, with 58% of women

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[107] *Id.*

[108] *Id.*

[109] *See, e.g.,* Brenda Akia, *Prioritise Enacting of the Marriage and Divorce Bill*, SATURDAY MONITOR, Mar. 21, 2015, http://www.monitor.co.ug/OpEd/Commentary/Prioritise-enacting-of-the-Marriage-and-Divorce-Bill/-/689364/2660260/-/erj7ua/-/index.html (accessed Mar. 16, 2016); Flavia Natubega, *Pass the Marriage and Divorce Bill. It's good for Uganda*, ACTIONAID, http://www.actionaidusa.org/uganda/stories/pass-marriage-and-divorce-bill-its-good-uganda (accessed Mar. 16, 2016); Moses Mulondo & Cyprian Musoke, *Kadaga resurrects Marriage and Divorce Bill*, NEW VISION, Feb. 19, 2015 http://www.newvision.co.ug/new_vision/news/1321036/kadaga-resurrects-marriage-divorce (last visited Mar. 16, 2016).

[110] *See, e.g.*, Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007, c. 2 § 3 (S. Africa) ("Any person ('A') who unlawfully and intentionally commits an act of sexual penetration and with a complainant ('B'), without the consent of B, is guilty of rape."); Sexual Offences Act, 2003, §§ 1-3 (U.K.) (criminalizing non-consensual "penetration" and "touching" where "B does not consent … and A does not reasonably believe that B consents," 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).

[111] WHO, GUIDELINES FOR MEDICO-LEGAL CARE FOR VICTIMS OF SEXUAL VIOLENCE 2, 13-14 (2003), *available at* http://whqlibdoc.who.int/publications/2004/924154628X.pdf.

[112] *See, e.g.,* CEDAW Committee, *Concluding Observations: Egypt*, para. 40, U.N. Doc. CEDAW/C/EGY/CO/7 (2010); Committee on the Rights of the Child (CRC Committee), *Concluding Observations: Costa Rica*, para. 64, U.N. Doc. CRC/C/CRI/CO/4 (2011); ESCR Committee, *Concluding Observations: Chile*, para. 53, U.N. Doc. E/C.12/1/Add.105 (2004); *Malta*, para. 41, U.N. Doc. E/C.12/1/Add.101 (2004); *Nepal*, para. 55, U.N. Doc. E/C.12/1/Add.66 (2001).

[113] Special Rapporteur on violence against women, its causes and consequences, *Integration of the Human Rights of Women and the Gender Perspective: Violence against Women, Intersections of Violence against Women and HIV/AIDS, Report of the Special Rapporteur on violence against women, its causes and consequences* (by Yakin Ertürk), para. 23, U.N. Doc. E/CN.4/2005/72 (2005).

[114] 2011 UDHS, *supra* note 11, at 256.

[115] UGANDA BUREAU OF STATISTICS, 2014 STATISTICAL ABSTRACT 160 (2014), *available at* http://www.ubos.org/onlinefiles/uploads/ubos/statistical_abstracts/Statistical_Abstract_2014.pdf [hereinafter 2014 STATISTICAL ABSTRACT]. It should be noted, however, that the NGO ActionAid has reported that for the year 2013,

believing that physical violence against women is justifiable in at least certain circumstances.[116] Finally, about three in ten Ugandan women age 15-49 have experienced sexual violence during their lifetimes.[117] Of these women, approximately 60% experience this sexual violence at the hands of a current husband or partner, and 20% at the hands of a former husband or partner.[118] Official statistics indicate that up to one-quarter of homicides caused by aggravated domestic violence can go unprosecuted, while only about half of reported rape and defilement cases, respectively, are prosecuted.[119]

28. 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,[120] and over 75% in a 2005 study reported having experienced some kind of sexual violence or harassment.[121] 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.[122] A 2007 study found that 23% of girls reported that their first sexual encounter was forced.[123] In addition, a 2010 report shows that 8% of girls age 16-17 have had sex with their teachers.[124] 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.[125]

C) Discrimination and Stigma against Women Living with HIV and AIDS

29. It is estimated that approximately 1.5 million Ugandans were living with HIV/AIDS in 2014, representing 7.3% of the total adult population,[126] a marked increase since 2005. According to a 2013 summary of the findings of surveys conducted by the National Forum of People with

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up to 360 deaths in Uganda were caused by DV. *See*, Carol Angir, *Violence Is a Fact of Life for the Women of Uganda*, ACTIONAID, May 28, 2015, http://www.actionaid.org/violenceagainstwomen (accessed Jan. 19, 2016).

[116] 2011 UDHS, *supra* note 11, at 230.

[117] 2011 UDHS, *supra* note 11, at 246.

[118] 2011 UDHS, *supra* note 11, at 245.

[119] 2014 STATISTICAL ABSTRACT, *supra* note 115. In 2011, for example, 181 deaths attributed to aggravated DV were reported, and only 133 were prosecuted (for a prosecution rate of about 74%). Official statistics indicate that only a miniscule percentage of prosecutions result in convictions. *See* UGANDA POLICE, ANNUAL CRIME AND TRAFFIC/ROAD SAFETY REPORT 2011, Appendix I, B.

[120] Karen M. Devries et al., *Violence against Primary School Children with Disabilities in Uganda: A Cross-Sectional Study, 14* BMC PUB. HEALTH 1017, tbl. 3 (2014), *available at* http://www.biomedcentral.com/1471-2458/14/1017.

[121] DIPAK NAKER, VIOLENCE AGAINST CHILDREN: THE VOICES OF UGANDAN CHILDREN AND ADULTS 26 (2005), http://raisingvoices.org/wp-content/uploads/2013/03/downloads/resources/violence_against_children.pdf.

[122] *Id.*, at 26.

[123] Ann Moore et al., Coerced First Sex among Adolescent Girls in Sub-Saharan Africa: Prevalence and Context, 11 AFR. K. REPROD. HLTH. 62-82 (2007).

[124] AMNESTY INTERNATIONAL, 'I CAN'T AFFORD JUSTICE': VIOLENCE AGAINST WOMEN IN UGANDA CONTINUES UNCHECKED AND UNPUNISHED 28 (2010), *available at* http://www.amnesty.org/en/library/info/AFR59/001/2010/en.

[125] *Id.*

[126] UNAIDS, "Uganda: HIV and AIDS estimates (2014)", http://www.unaids.org/en/regionscountries/countries/uganda.

HIV/AIDS Networks in Uganda, there is a high level of stigmatization and discrimination against people living with HIV in the Uganda.[127] Women have been disproportionately affected by the recent upsurge in HIV prevalence in Uganda, and studies have shown that they are generally more prone to stigma and discrimination than men.[128] This has further been exacerbated by the passage of the HIV and AIDS Prevention and Control Act of 2014 (HIV/AIDS Act) which contains several provisions that will further fuel stigmatization and discrimination, which might consequently hinder the public health response to a recent increase in the HIV prevalence rate in Uganda.

30. First, the 2014 HIV/AIDS Act authorizes forced HIV testing without consent, weakening confidentiality protections for people living with HIV and criminalizing HIV transmission.[129] The bill singles out women by subjecting pregnant women and survivors of sexual assault to compulsory HIV blood testing,[130] which deepens the stigma against women living with HIV and may deter women from seeking essential health care. Second, the Act expressly permits third-party disclosure of HIV status without consent, based solely on the opinion of a "medical practitioner or other qualified officer."[131] Non-consensual disclosure of HIV status places women at risk of physical, sexual, and psychological abuse. Finally, the Act criminalizes attempted transmission and intentional transmission of HIV,[132] which could cause people living with HIV to opt not to seek necessary health services for fear of intrusive investigations and potential violation of confidentiality.

31. The 2014 HIV/AIDS Act does include provisions that require the government to devise measures to ensure the right of access to HIV treatment in all "health facilities, goods and services including essential medicines" on a non-discriminatory basis. However, the above highlighted sections of the bill that enable stigmatization, besides violating the rights of people living with HIV/AID, threaten to severely hinder efforts to reverse the upsurge in HIV prevalence in Uganda by limiting their access to essential medical treatments. As UNAIDS reports, programs to reduce stigma and discrimination and increase access to justice "not only help realize human rights and access to justice in the context of HIV, they are also critical

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[127] UNAIDS and The National Forum of PWHA Networks in Uganda, THE PEOPLE LIVING WITH HIV STIGMA INDEX: UGANDA (the "NAFOPHANU REPORT") vii (Aug. 2013), *available at* http://www.stigmaindex.org/sites/default/files/news-attachments/PLHIV%20Sigma%20Index%20Report%20-%20Uganda%20Country%20Assessment%202013.pdf.

[128] *Id.*, at 3.

[129] HIV AND AIDS PREVENTION AND CONTROL ACT, 2014, Part III, sec. 13(C) & 14 (2014) (Uganda), *available at* http://www.parliament.go.ug/new/images/stories/acts/2014/HIV%20and%20AIDS%20prevention%20and%20control%20act%202014.pdf [hereiniafter HIV/AIDS ACT].

[130] *Id.*; *see also* HUMAN RIGHTS WATCH, COMMENTS TO UGANDA'S PARLIAMENTARY COMMITTEE ON HIV/AIDS AND RELATED MATTERS ABOUT HIV/AIDS PREVENTION AND CONTROL (2009), *at* https://www.hrw.org/news/2009/11/06/comments-ugandas-parliamentary-committee-hiv/aids-and-related-matters-about-hiv/aids.

[131] HIV/AIDS ACT, *supra* note 129, at Part III, sec. 18.

[132] *Id.*, at Part VIII, sec. 41.

enablers to the success of basic HIV prevention and treatment programmes."[133] During the review of Uganda in 2015, the Africa Commission on Human and People Rights expressed concern regarding the criminalization of the transmission of HIV/AIDS in the 2014 HIV/AIDS Act since it "has the potential to negatively affect the national response on HIV/AIDS and also infringe upon the basic rights of persons living with HIV/AIDS.[134] The Commission recommended that the government revise the Act "to ensure that it fully conforms with Uganda's regional and international human rights obligations."[135]

III. Questions and Recommendations

A) Questions

i. What concrete measures is the government implementing to ensure achievement of the Sustainable Development Goal of reducing the MMR to less than 70 deaths per 100,000 live births? What steps is the government taking to increase women and girls' access to antenatal, delivery and postnatal care, particularly to adolescents, low-income women and those living in rural areas? What steps is the government taking to implement the recommendation from the previous UPR to increase its health budget allocation to 15% of the total budget in accordance with its commitment under the Abuja Declaration?

ii. What measures is the government taking to lift its reservation on the Maputo Protocol and revise its laws on abortion to allow the procedure in situations where the pregnancy resulted from rape or incest, and in cases of fetal abnormality, in line with international and regional human rights standards? What steps is the government taking to address the delay in the implementation of the Standard and Guidelines on abortion, and ensure that health care facilities and health care professionals are well equipped to provide abortion and post-abortion care?

iii. What measures is the government implementing to reduce the high unplanned and unwanted pregnancy rates, particularly among adolescents, and the high unmet need for contraceptives? What is the plan of the government to address the various challenges women and adolescent girls encounter in accessing contraceptives including stock-outs, misconceptions and misinformation about the side-effects of contraceptives?

iv. What concrete efforts is the government taking to implement the Domestic Violence Act? When does the government plan to pass the Sexual Violence Bill? What is the government's plan to re-table the Marriage and Divorce Bill? What are the measures the government

[133] UNAIDS, KEY PROGRAMMES TO REDUCE STIGMA AND DISCRIMINATION AND INCREASE ACCESS TO JUSTICE IN NATIONAL HIV RESPONSES 5-6, (2012), *available at* http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/document/2012/Key_Human_Rights_Programmes_en_May2012.pdf.

[134] African Commission on Human and Peoples' Rights, *Concluding Observations and Recommendations on the 5th Periodic State Report of the Republic of Uganda (2010-2012),* para. 76 (2015).

[135] *Id.,* at para. 113.

implementing the curb the high physical and sexual violence against women and children and ensure that incidences are reported and prosecuted in accordance with the law?

v. What steps are being taken to amend the provisions of the HIV and AIDS Prevention and Control Act of 2014 that further fuel stigma and discrimination against people living with HIV/AIDS and violate their right to confidentiality and consent?

B) Recommendations

i. The government should intensify its efforts to address the high maternal mortality rate including by ensuring women's and girls' access to antenatal, delivery and postnatal care, particularly adolescents, low-income women and those living in rural areas. The government should increase its health budget allocation to 15% of the total budget in accordance with its commitment under the Abuja Declaration.

ii. The government should lift its reservation on the Maputo Protocol, revise its laws on abortion to allow the procedure in situations where the pregnancy resulted from rape or incest, in case of fetal abnormality, and clarify the grounds for abortion in the current laws, in accordance international and regional human rights law. The government should take immediate steps to implement the Standard and Guidelines on abortion, including by disseminating the document to all health care facilities, and ensure that health care facilities and health care professionals are well equipped to provide abortion and post-abortion care.

vi. 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.

vii. 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 a full range of comprehensive and gender-sensitive services for victims of violence.

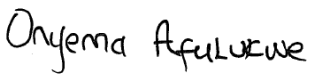
viii. The government should implement strategies to reduce the stigmatization and discrimination faced by women living with HIV/AIDS, especially in health care facilities. The government should examine and amend the laws and policies already in place to ensure that they prevent and prohibit discrimination against those living with HIV/AIDS. Further, it should implement the concluding observation from the African Commission on Human and Peoples' Rights and

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.

Sincerely,

Evelyne Opondo
Regional Director
Africa Program
Center for Reproductive Rights

Moses Mulumba
Executive Director
Center for Health, Human Rights & Development



Onyema Afulukwe
Senior Legal Advisor
Africa Program
Center for Reproductive Rights