

**CENTER
FOR
REPRODUCTIVE
RIGHTS**

May 15, 2009

African Commission on Human and Peoples' Rights

Re: Supplementary information on Uganda scheduled for review by the African Commission on Human and Peoples' Rights during its 45th Session

Dear Honourable Commissioners:

This letter is intended to serve as a supplement to the report submitted by Uganda to the African Commission on Human and Peoples' Rights as per Article 62 of the African Charter on Human and Peoples' Rights [African Charter],¹ which will be reviewed by the African Commission in its 45th Session. The Center for Reproductive Rights [CRR], an international non-governmental organization, hopes to further the work of the African Commission by providing independent information concerning the rights protected in the African Charter. This letter also refers to the African Charter on the Rights and Welfare of the Child [Children's Charter],² which Uganda has ratified,³ and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa [Maputo Protocol]⁴ where these instruments can give further content to these rights. Uganda has signed, but not ratified, the Maputo Protocol.⁵

This letter highlights abuses several areas of concern relating to reproductive rights and HIV in Uganda, including : inadequate access to reproductive health care services and health care services for HIV-positive women; violence and discrimination against HIV-positive women; and troubling provisions contained in the HIV and AIDS Prevention and Control Bill, 2008, currently before the Ugandan Parliament.

A government's commitment to ensure reproductive rights should receive serious attention because these rights are fundamental to women's and girls' equality and health. The African regional system has offered the most explicit recognition and protection of these rights through the Maputo Protocol. While Uganda has not yet ratified the Protocol, its signature obligates it not to act in a way that undermines "the full realisation of the rights [t]herein recognized."⁶ Furthermore, the key human rights provisions that protect the sexual and reproductive rights of women – the rights to life, health, dignity and non-discrimination, among others – are included in the African Charter. The African Charter requires states to take appropriate measures to ensure that discrimination against women is eliminated and that women's health is protected.⁷ It also obliges states parties "to ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions."⁸ The Children's Charter similarly protects girls in this manner.

Despite the human rights protections contained in these regional charters and protocols, and in the international treaties Uganda has ratified, the reproductive rights of women and girls in Uganda continue to be neglected and, at times, blatantly violated. An area of particular concern is the rights of those affected by HIV/AIDS, particularly women living with HIV. Notwithstanding the fact that the Ugandan government has implemented several policies aimed at preventing the spread of HIV/AIDS, Uganda still faces a severe HIV epidemic.⁹ While the proposed HIV Bill includes some positive language, it also

contains discriminatory and dangerous provisions that could result in further rights violations against people living with HIV.

We wish to bring to the African Commission's attention the following areas of concern, which affect the reproductive health rights of women and girls.

I. THE RIGHT TO REPRODUCTIVE HEALTH CARE (ARTICLES 2, 4, AND 16 OF THE AFRICAN CHARTER)

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 parties to take necessary measures to ensure the health of their people.¹⁰ Existing international human rights standards on the right to life have been interpreted to require governments to take "positive measures" aimed at preserving life.¹¹ 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.¹²

These clauses of the African Charter obligate the Ugandan government to ensure women's access to reproductive health services. In the absence of these services, women may experience unsafe pregnancies, possibly resulting in death or illness due to inadequate maternal health care. In cases of unplanned or unwanted pregnancies, women may seek unsafe illegal abortions that could also cause serious complications or death.

A. MATERNAL HEALTH

Maternal death is defined as any death that occurs during pregnancy, childbirth, or within two months after birth or the termination of a pregnancy.¹³ Maternal mortality levels and trends serve as indicators of the health status of women and may point to violations of civil and political rights, as well as economic, social, and cultural rights. High rates of maternal mortality could be linked to violations of women's rights to life, personal liberty and security, freedom from inhuman and degrading treatment, health, education, information, and freedom from discrimination. The African Charter, the Children's Charter, and the Maputo Protocol all guarantee these rights.

The committees that monitor compliance with the International Covenant on Economic, Social and Cultural Rights [Economic, Social and Cultural Rights Covenant], the International Covenant on Civil and Political Rights [Civil and Political Rights Covenant], and the Convention on the Elimination of all forms of Discrimination Against Women [CEDAW] have framed the issue of maternal mortality as a violation of women's right to health and right to life.¹⁴ The Human Rights Committee, the monitoring body of the Civil and Political Rights Covenant, has noted that the inherent right to life should not be understood in a restrictive manner and that states should take positive measures, particularly to increase life expectancy.¹⁵

The recognition of maternal mortality as a human rights issue has been underscored by the United Nations Special Rapporteur on the Right to Health:

Maternal mortality is not just a health or humanitarian issue – it is a human rights issue. Avoidable maternal mortality violates women's rights to life, health, equality and non-discrimination. The human rights community should take up maternal mortality just as vigorously as it does extrajudicial executions, disappearances, arbitrary detention, and prisoners of conscience.¹⁶

Reduction of maternal mortality is also one of the major goals of several recent international conferences and has been included in Goal 5 of the Millennium Development Goals agreed to by Uganda.¹⁷

The government of Uganda has repeatedly expressed its commitment to improving maternal health. With the goal of “reduc[ing] mortality, morbidity, and fertility and the disparities therein”,¹⁸ the 1999 National Health Policy commits to ensuring access to a “Minimum Health Care Package” which includes essential antenatal and obstetric care, family planning, adolescent reproductive health, and programs that address violence against women.¹⁹ In 2008, the Ugandan government launched the Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity, which aims to improve the Ugandan healthcare system in the areas of maternal and newborn care.²⁰ However, according to the Ugandan Delegation’s April 2009 statement to 42nd Session of the Commission on Population and Development, the road map is still “awaiting budgetary provisions for implementation.”²¹

Although the Ugandan government has identified maternal health as a priority issue, complications with pregnancy and childbirth are still one of the leading causes of morbidity and mortality among Ugandan women.²² According to the government’s 2006 figures, there are approximately 435 maternal deaths per 100,000 live births each²³. This translates into approximately 16 women dying from pregnancy-related causes every day.²⁴ Ministry of Health officials have indicated that because of underreporting of maternal deaths this figure could be higher.²⁵ The majority of these deaths were due to obstetric complications including hemorrhage, sepsis, eclampsia, obstructed labor and unsafe abortion.²⁶

The overall weakness of the health sector is a major contributing factor to this high rate of maternal deaths. The Uganda Human Rights Commission has identified inadequate funding, mismanagement of existing funds, and inadequate human resources in the health sector as key problems and noted that “increased investment in the health sector is needed including getting more trained health workers and improving the infrastructure, if Uganda is to succeed in combating and averting maternal deaths.”²⁷

While the percentage of women receiving at least some prenatal care is relatively high,²⁸ the 2006 Uganda Demographic Health Survey [2006 UDHS] concluded that the ante-natal care [ANC] services provided in Ugandan health facilities are inadequate.²⁹ According to the 2007 Uganda Service Provision Assessment Survey [2007 USPAS], of the seven out of ten health care facilities in Uganda that offer ANC services,³⁰ fewer than one-quarter of those facilities have all of the essential equipment and supplies necessary to do so. Many facilities lack blood pressure machines, foetoscopes, iron and folic acid tablets, or the tetanus toxoid vaccine, which protects against neonatal tetanus.³¹ At some facilities, ANC clients frequently do not receive counseling about family planning, delivery plans, exclusive breastfeeding, nutrition, or risk signs and symptoms during pregnancy.³² The lack of these services places pregnant women at greater risk for complications and infections that may cause death or serious illness for the mother, baby, or both.

Problems abound with both access to and quality of delivery services as well. In the five years preceding the 2006 UDHS, only 41 percent of all deliveries occurred in health facilities.³³ Of these deliveries, 29 percent occurred in public facilities and 12 percent took place in private facilities.³⁴ Approximately 63 percent of the women who accessed health facilities were from urban areas of Uganda.³⁵ Rural births are more than half as likely as urban births to be assisted by health care workers (37 compared with 80 percent).³⁶ Only about 50 percent of health care facilities in Uganda offer normal delivery services³⁷ and fewer than half of these have all the necessary infection control supplies (soap, running water, sharps box, disinfecting solution, and clean latex gloves).³⁸ The most commonly missing item is water.³⁹ Furthermore, only one-third of these facilities have the basic equipment and supplies needed for conducting normal deliveries (such as scissors or blades and cord clamps or ties), while only one-tenth of the facilities have all of the instruments to ensure that delivery equipment is properly sterilized.⁴⁰ Moreover, these supplies are more likely to be available at private, as opposed to government, health care facilities.⁴¹

Caesarean sections are available at only 5 percent of all facilities in the country, with private facilities more than twice as likely as government facilities to offer the procedure. This presents a significant obstacle to women who seek to access quality and comprehensive care. Many women are unable to afford treatment at private health facilities because, unlike public facilities, private facilities charge user fees to patients.⁴²

While the 2007 USPAS indicates that more comprehensive delivery services are more likely to be available at hospitals rather than smaller health care facilities, the state of those hospitals can also be poor. Mulago Hospital in Kampala, a national referral hospital and the largest hospital in the country, suffers from a dearth of staff, supplies, and space. During a March 2009 visit from Ugandan Parliamentarians, the labour ward which was designed to handle 20 women, held more than 100 new mothers.⁴³ Some mothers who delivered were lying on the floors with their babies.⁴⁴ The head of the maternity department explained that due to understaffing, “some times medical students are called in to attend to delivering mothers”.⁴⁵ Hygiene is a serious issue with personnel not having the time to clean beds before they are used again for other women to deliver⁴⁶; the hospital often lacks gloves and the floors are spattered with blood and strewn with dirty needles.⁴⁷

B. ACCESS TO FAMILY PLANNING SERVICES AND INFORMATION

The 2006 UDHS shows that only 20% of all Ugandan women are using some form of contraceptive⁴⁸ and a high unmet need for family planning among Ugandan women. In the five years preceding the survey, 33 percent of the births to women between the ages of 15 and 49 were mistimed, and 13 percent were unwanted at the time of conception.⁴⁹

Contraceptives may be inaccessible to a number of Ugandan women because they are unable to access private health care facilities due to the user fees that these facilities charge for family planning services. According to the 2006 UDHS, “[t]he most common single source of contraceptives in Uganda is private hospitals and clinics, which supply 43 percent of all users of modern methods.”⁵⁰ Although any government-supplied contraceptive method should be free of charge, whether or not it is provided in a public or private facility, 51 percent of private facilities charged a user fee for their family planning services.⁵¹

Public facilities, such as government hospitals and health centers, each only supply 16 percent of users of contraceptives.⁵² Of the remaining contraceptive users, eight percent receive their methods from shops, while seven percent obtain them from pharmacies.⁵³ Furthermore, the 2006 UDHS reports that “[t]he contribution of private medical sources in the provision of family planning supply has continued to increase since 1995, as public sources continue to decline in use.”⁵⁴

The presence of user fees, in addition to other obstacles to obtaining contraception, such as the unavailability of a preferred contraceptive method⁵⁵, improper counseling services⁵⁶, lack of information about contraceptive methods⁵⁷, and absence of supplies necessary to insert certain methods⁵⁸ may contribute to the low prevalence of contraceptive use in Uganda.

C. ABORTION

Unsafe abortion is one of the most easily preventable causes of maternal death and disability. Where death does not result from unsafe abortion, women may experience long-term harms, such as uterine perforation, chronic pelvic pain, or infertility. Despite Uganda’s stated commitment to reducing maternal mortality, its abortion law is among the most restrictive in the world, permitting abortion only to save the

life of the pregnant woman.⁵⁹ As in most African countries, it has its origins in the laws of colonial predecessors—nations that have since reformed their own laws.

The committees that oversee compliance with the International Covenant on Civil and Political Rights, International Covenant on Economic Social and Cultural Rights, Convention on the Elimination of All Forms of Discrimination Against Women, and the Convention on the Rights of the Child have all characterized high rates of maternal mortality caused by abortion as violations of the rights to health and life, and have explicitly asked states parties to review legislation criminalizing abortions.⁶⁰

Restrictive abortion laws also discriminate against women on the basis of sex, age, and economic status, violating the right to be free from discrimination as elaborated in Articles 2, 3, and 18(3) of the African Charter and Article 2(1) of the Maputo Protocol.⁶¹ Denying access to a medical procedure that only women need exposes women to health risks not experienced by men, because only women incur the direct physical and emotional consequences of an unwanted or dangerous pregnancy. Such laws also discriminate against young and low-income women who are less likely to have the resources to access safe abortion in Uganda or abroad. Poorer women are forced to have clandestine abortions, often in unsanitary conditions at the hands of untrained practitioners, greatly increasing the risk of abortion-related complications.⁶² Girls are also less likely to be able to access and afford safe abortion services and may feel additional pressure to terminate a pregnancy because of the social stigma of pregnancy and the difficulties of continuing their education. However, even abortions performed by trained health care providers may still be unsafe because, as one doctor at Makerere University explained, “Many of our doctors have not been well trained to offer safe methods or are working under unsafe conditions.”⁶³

Each year an estimated total of 297,000 induced abortions (both legal and illegal) are performed in Uganda with approximately 1200 women dying each year from unsafe abortions⁶⁴ and nearly 85,000 women treated for complications.⁶⁵ The most common complications include severe abdominal pain, fever, weakness, anemia and death. Women who experience complications from abortions often treat themselves with herbal medicines because they cannot afford to seek treatment in a health facility, or they want to conceal the fact that they underwent an abortion.⁶⁶ Furthermore, a survey of Ugandan women also suggests that women do not seek medical treatment for abortions or related complications because they fear negative reactions and judgment from health care providers.⁶⁷ Even when women do seek post abortion care, “the drugs, equipment, and skills are insufficient” noted an Assistant Commissioner for Reproductive Health in the Ministry of Health.⁶⁸ The lack of access to safe abortions increases the burden on the Ugandan health care system, particularly public hospitals which treat the most severe abortion-related complications,⁶⁹ and places Ugandan women at risk of long-term disabilities or death.

II. RIGHTS ABUSES EXPERIENCED BY WOMEN LIVING WITH HIV/AIDS (ARTICLES 2, 3, 4, 5 AND 18 OF THE AFRICAN CHARTER)

Accurate information on prevention and treatment of sexually transmitted infections (STIs) is a key component of sexual and reproductive health. The failure to inform women about prevention and treatment of STIs, particularly HIV/AIDS, is an infringement on their rights to life and health. Article 14(1) (d) of the Maputo Protocol expressly articulates that women have the right to self-protection and to be protected against STIs, including HIV/AIDS.⁷⁰ The Maputo Protocol also expresses a state’s duty to protect girls and women from practices and situations that increase their risk of exposure to HIV, such as child marriage.⁷¹

Existing international human rights standards on the right to equality, to the highest attainable standard of health, and to life have all been interpreted to guarantee women’s rights in relation to HIV/AIDS. The CEDAW Committee has acknowledged that inequality and discrimination against girls and women, such

as sexual violence or membership in a disadvantaged group, play a role in making women more vulnerable to HIV infection.⁷²

A. HIV/AIDS RATES

Despite the praise that Uganda has received as an example of a country that successfully implemented a campaign against HIV/AIDS throughout the 1990s, Uganda still faces a severe HIV epidemic.⁷³ By 2007, a cumulative total of approximately 2.6 million people in Uganda had contracted HIV.⁷⁴ Of these people, approximately 1.6 million have died and roughly 1 million are living with HIV.⁷⁵ In addition, about 1.2 million children have been orphaned by AIDS.⁷⁶ The current HIV prevalence rate in Uganda is estimated to be 6.4 percent⁷⁷ with prevalence higher among adult women (7.5 percent) as compared to men (5 percent).⁷⁸ Additionally, prevalence rates are higher among young women aged 15 – 24 (3.9 percent) than young men of the same age (1.3 percent).⁷⁹ These statistics show that HIV/AIDS is a virus that disproportionately impacts women. However, the measures that the Ugandan government is taking to combat the spread of HIV fail to address this reality.

Recently, Uganda has experienced an increase in the number of new HIV cases reported.⁸⁰ This increase in new HIV/AIDS cases may be partially attributable to the government's emphasis on abstinence-based prevention programs, which are detrimental to Ugandan women.⁸¹ Prior to 2003, the Ugandan government's HIV prevention strategy included encouraging abstinence from sexual activity until marriage, advising sexually active persons to be faithful to one partner, and lastly, encouraging condom use.⁸² Since 2003, the Uganda government has accepted funding from the United States government for programming that places a greater emphasis on "abstinence-only" prevention strategies, which exclusively promote abstinence at the expense of the multi-pronged approach described above. An emphasis on abstinence until marriage is both flawed and dangerous since women are often forced into non-consensual sexual relations and marriage itself can actually be a risk factor for contracting HIV.⁸³

Stephen Lewis, the former UN Special Envoy for HIV/AIDS in Africa, stated that an emphasis on abstinence at the expense of condom distribution is a "distortion of the preventative apparatus and is resulting in great damage and undoubtedly will cause significant numbers of infections which should never have occurred."⁸⁴

B. INADEQUATE HEALTH CARE AND DISCRIMINATORY TREATMENT OF HIV-POSITIVE WOMEN

Just as Ugandan health care facilities are ill-equipped to provide the reproductive health care services discussed above, they are also inadequately equipped to provide HIV care and counseling. Only about three out of 10 health facilities in Uganda have an HIV testing system,⁸⁵ while only about six out of 10 facilities provide care and support services for HIV/AIDS patients.⁸⁶ Roughly eight percent of facilities prescribe ARVs and/or provide medical follow-up for HIV/AIDS patients.⁸⁷

Specifically, Ugandan health facilities lack services for women living with HIV, particularly in the area of reproductive health. Although women living with HIV require specialized care and counseling throughout their reproductive lives, Ugandan health facilities are unable to provide this specialized care.⁸⁸ In fact, health care workers in some Ugandan districts have not received any training specific to HIV-positive women.⁸⁹ Furthermore, prevention of mother-to-child transmission [PMTCT] services are available in less than one-third of Ugandan health care facilities and concentrated in hospitals and facilities in Kampala, Central and North Central regions.⁹⁰

Moreover, the Ugandan government has failed to develop policy guidelines on reproductive health care for HIV-positive women.⁹¹ The lack of reproductive health guidelines for women living with HIV

demonstrates that the Ugandan government is neglecting to address the unique needs and rights of this group.

C. SEXUAL AND DOMESTIC VIOLENCE AND ITS IMPACT IN THE CONTEXT OF HIV

Article 5 of the African Charter provides for respect of dignity and prohibits torture and inhuman or degrading treatment.⁹² The Charter also guarantees the rights to life and health.⁹³ All these rights are violated when women have no protection from rape, domestic violence, and other forms of violence. Furthermore, Articles 2, 3 and 18(3)—which provide for the equal protection for both sexes of the Charter’s rights and prohibit discrimination against women—are violated where governments fail to enact and enforce laws protecting women’s physical safety and integrity.⁹⁴ Several provisions of the Children’s Charter and the Maputo Protocol also protect women and girls from physical and emotional violence. Article 27 of the Children’s Charter requires states parties to take measures to protect the child against all forms of sexual abuse, exploitation, torture, and inhuman and degrading treatment, including physical and mental injury and sexual abuse.⁹⁵ Further, Article 21 requires states parties to take action to eliminate harmful social and cultural practices.⁹⁶ Similarly, Article 3(4) of the Maputo Protocol requires states parties to take measures to protect women from all forms of sexual violence.⁹⁷

Sexual and domestic violence against women occurs frequently in Uganda. Such violence compromises the ability of these women to practice safe sex and protect themselves from HIV/AIDS, and other STIs. The 2006 UDHS reports that 68% of ever-married women experienced some form of violence from their husband or intimate partner.⁹⁸ According to the same survey, approximately 24 percent of women aged 15 to 49 reported that the first time they engaged in sexual intercourse was against their will.⁹⁹ Additionally, about four in ten Ugandan women experience sexual violence during the course of their lifetimes.¹⁰⁰ Of those women who do suffer sexual violence, approximately 66% experience such violence at the hands of a current or former husband or partner.¹⁰¹ Victims of sexual violence, particularly in the form of rape, are exposed to the possibility of contracting HIV from their assailant. But weaknesses in the health care system mean that survivors of sexual violence have difficulty accessing the post-exposure prophylaxis (PEP) necessary to prevent contracting HIV from sexual assault.¹⁰² This problem is particularly acute in remote areas of Northern Uganda where doctors are reluctant to work; as the staff member of one women’s rights organization explained, “PEP could be available in health units, but when we refer the survivors there for medication, they find no one to help them. There is a shortage of doctors....”¹⁰³

Not only does violence increase women’s chances of becoming HIV-positive, but HIV-positive women in Uganda are also victims of violence because of their HIV status. People living with HIV suffer stigma and discrimination in many countries, including Uganda.¹⁰⁴ Despite the existence of HIV/AIDS programs which aim to fight such attitudes and to encourage those living with HIV to seek treatment and support, attitudes have been slow to change in Uganda. Generally, only about 26 percent of women, and 36 percent of men, have positive attitudes towards persons that are living with HIV or AIDS.¹⁰⁵ As a result of this persistent stigma and a fear of violence, many women who demonstrate HIV/AIDS symptoms refuse to undergo testing and seek treatment for this virus. These women fear that if their partners learn that they are HIV-positive, they may accuse them of bringing HIV into the home, evict them from the home, or subject them to domestic violence.¹⁰⁶ In 2008 alone, five cases of women being murdered by their husbands once they learned that their wives were HIV-positive, were reported.¹⁰⁷

One HIV-positive woman in Masindi described her experience as follows:

I have experienced a lot of suffering ever since I tested HIV positive. My husband beats me accusing me of having brought the disease to the home. He refused to go for testing and he does not want me to go for treatment. When he learns that I went to the health centre for

medication, he beats me saying that I am embarrassing him ... that I am showing everybody that we are sick. Now I fear going to services. When I manage to go to the health centre, there are things I do not accept to take, like for PMTCT, I cannot take drugs [to] my home, I just get the nevirapine. I cannot take with me things given in the basic care package because he will ask me where I got them from. When it comes to sex, I have no say, health workers tell us that we should use condoms to avoid re-infection but I cannot ask him to use condoms to prevent re-infection[. H]e would beat me.”¹⁰⁸

The Constitution of the Republic of Uganda codified the right to non-discrimination, equal protection and equality before the law, the right to privacy, and the right to medical treatment. In addition, Uganda enacted an Equal Opportunities Act and is in the midst of developing a Domestic Relations Bill. However, this legislative network lacks effective enforcement in part due to “complacency of law enforcement agencies” and corruption.¹⁰⁹

D. PROBLEMS WITH THE HIV AND AIDS PREVENTION AND CONTROL BILL, 2008

In order to provide greater protections to people living with HIV in Uganda, the Ugandan Parliament is currently considering a draft bill titled the “HIV and AIDS Prevention and Control Bill, 2008” [the HIV Bill].¹¹⁰ This bill addresses various aspects of care, prevention and other matters related to HIV/AIDS. The Ugandan parliament introduced this legislation in response to research findings that demonstrated that Uganda’s HIV prevalence rate had stagnated at around 6.5 percent, and indicated that an increasing number of infections occurred among married couples.¹¹¹ However, the HIV Bill contains several problematic provisions and there have been complaints about inadequate engagement with civil society, people living with HIV, and other groups that are directly affected by the HIV Bill’s provisions.¹¹²

Several of the HIV Bill’s provisions threaten to negatively impact HIV-positive women living in Uganda including provisions that criminalize transmission of HIV/AIDS, permit non-consensual disclosure of one’s status, and allow mandatory HIV testing without the consent of the patient in certain circumstances.

Article 41 of the HIV Bill criminalizes the intentional transmission of HIV and AIDS and provides for both civil and criminal penalties.¹¹³ In its current form, Article 41 risks subjecting HIV-positive women, who are already vulnerable to human rights violations, to further abuses. First, women are more likely than their partners to receive HIV tests and learn of their sero-status because HIV testing is routinely provided as part of prenatal health care. Therefore, since women are more likely to know of their sero-status, men may be more likely to charge their female partners with the intentional transmission of HIV. Additionally, imposing civil and criminal penalties on the intentional transmission of HIV and AIDS further stigmatizes people living with HIV, who may choose to forego HIV treatment and care for fear of incurring civil and/or criminal penalties in this process. Thus, the criminalization of HIV transmission is ineffective in combating the spread of HIV, and it threatens to undermine HIV prevention efforts and exacerbate the stigma and discrimination already experienced by people living with HIV, particularly women, when they seek access to health facilities.

Articles 15 and 16 of the HIV Bill allow health care providers to release the results of an HIV/AIDS test to a patient’s spouse without the patient’s consent.¹¹⁴ Nonconsensual disclosure of women’s status exposes them to stigma, discrimination, and violence.¹¹⁵ This is particularly the case when a woman’s status is disclosed to her spouse. If women fear that health care providers will disclose their HIV sero-status to their partners without their consent, they may be discouraged from seeking health care services, which could undermine the government’s public health initiatives around HIV and reproductive health.¹¹⁶

Finally, Article 7 and Article 13 of the HIV Bill, which allow for HIV/AIDS testing without the consent of the individual being tested, are likewise problematic. Article 7 subjects pregnant women to compulsory HIV testing.¹¹⁷ Presumably, the HIV Bill requires testing of pregnant women so that they are able to seek PMTCT treatment if HIV-positive. However, this non-consensual testing of pregnant women has grave public health and human rights implications.

Mandatory testing can diminish women's confidence in the health care system and undermine the government's efforts to improve maternal health and curb the HIV epidemic. The International Guidelines on HIV/AIDS and Human Rights recognize that the compulsory testing of pregnant women is a coercive measure that is ineffective in combating the spread of HIV and restricts the human rights of the individual.¹¹⁸ According to these guidelines, "[m]any HIV programmes targeting women are focused on pregnant women but these programmes often emphasise coercive measures directed toward the risk of transmitting HIV to the foetus, such as mandatory pre- [n]atal testing."¹¹⁹ Ultimately, these programmes "result in reduced participation and increased alienation of those at risk of infection"¹²⁰ and "these coercive measures drive people away from prevention and care programmes, thereby limiting the effectiveness of public health outreach."¹²¹ Thus, compulsory testing of pregnant women may discourage Uganda women from accessing the public health care system, which in turn, would undermine the Ugandan government's ability to prevent the spread of HIV and make improvements in available maternal health care. Furthermore, PMTCT treatment is only available in one-third of health facilities throughout Uganda and as indicated above only 41% of all women deliver in health care facilities, where they can best receive the services necessary to prevent HIV transmission during delivery. 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.

In addition to the harmful public health consequences, compulsory testing of pregnant women violates a range of their human rights. The Maputo Protocol prohibits performing medical experimentation, such as HIV testing, on women in the absence of their informed consent to such procedures.¹²² This objective also seriously curtails the autonomy and privacy of women living with HIV. One scholar in this field noted,

[m]andatory HIV testing in any situation is the most problematic of any testing strategy . . . it involves very significant limitations of individual autonomy and deep incursions into the domain of individual privacy. In pregnancy . . . mandatory HIV testing threatens to create a situation where [the woman's] moral value is secondary to that of her yet-to-be-born-child. The most serious objection to mandatory testing schemes is the denial of dignity.¹²³

III. QUESTIONS FOR THE GOVERNMENT OF UGANDA

On the basis of this information, we respectfully request that the Commission raise the following issues with the government of Uganda:

1. When does the Ugandan government intend to ratify the Maputo Protocol? Does it plan to do so without reservations? What steps is the government taking to ensure that its reproductive rights obligations under regional and international human rights law are domesticated and implemented at the national level?
2. What measures is the government taking to comprehensively address maternal mortality and morbidity and to ensure that women have access to safe and affordable quality maternal health

services? What is the government doing to address the key service provision gaps identified in the 2007 Uganda Service Provision Assessment Survey? When and how much money will be allocated to implementing the Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity? What steps is the government taking to meet its commitment to allocate 15% of its national budget to health?

3. What measures are being taken to ensure that women have consistent and affordable access to family planning methods and information? What efforts are being taken to create greater access to and familiarity with the female condom, which allows women to protect themselves from HIV?
4. What measures are being taken to review the existing abortion laws, health policies, and guidelines and bring them in line with the international and regional human rights standards binding Uganda, and to remove provisions regarding abortion from the penal code? What measures are being taken to promptly address the issue of unsafe abortion, which is one of the major causes of maternal mortality? What measures are being taken to ensure access to respectful and comprehensive post-abortion care for women and girls who have complications resulting from unsafe abortion?
5. What measures is the government taking to address the problem of rampant domestic and sexual violence? When will the Domestic Violence Bill become law and how much funding will be allocated to ensure implementation of the law, including providing shelter and redress for victims of domestic violence? What steps is the government taking to address the problem of rape within marriage?
6. How is the government addressing the risks of domestic violence faced by HIV-positive women and the complications this creates for seeking needed health care services? How is the government responding to concerns raised by civil society regarding provisions of the HIV Bill which expose those living with HIV to further stigmatization and rights violations, particularly women through mandatory testing of pregnant women and nonconsensual partner disclosure?

A significant gap remains between the provisions of the African Charter and the reality of women's reproductive health and lives in Uganda. We hope that the information is useful during the Commission's review of the Ugandan government's compliance with the provisions of the African Charter. If you have any questions, or would like additional information, please do not hesitate to contact the undersigned.

Sincerely,



Elisa Slattery
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Center for Reproductive Rights

¹ African Charter on Human and Peoples' Rights, (*adopted* June 26, 1981) O.A.U. Doc. CAB/LEG/67/3/Rev.5, 21 I.L.M. 58, art. 4 (1982) (*entry into force* Oct. 21, 1986) [hereinafter African Charter].

² African Charter on Rights and Welfare of the Child, (*adopted* July 11, 1990) O.A.U. Doc. CAB/LEG/24.9/49 (*entry into force* Nov. 29, 1999) [hereinafter Children's Charter].

³ Uganda ratified the Children's Charter on August 17, 1994. See <http://www.africa-union.org/root/AU/Documents/Treaties/List/African%20Charter%20on%20the%20Rights%20and%20Welfare%20of%20the%20Child.pdf>.

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- ⁴ Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, (*adopted* July 11, 2003), O.A.U. Doc Cab/LEG/66.6 (*entry into force* Nov. 25, 2005) [hereinafter Maputo Protocol].
- ⁵ Uganda signed the Maputo Protocol on December 18, 2003. See <http://www.africa-union.org/root/AU/Documents/Treaties/List/Protocol%20on%20the%20Rights%20of%20Women.pdf>.
- ⁶ Maputo Protocol, *supra* note 4, art. 26.
- ⁷ African Charter, *supra* note 1, art. 18(3) ("The State shall ensure the elimination of every discrimination against women and also ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions."). See also African Charter, *supra* note 1, 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.").
- ⁸ African Charter, *supra* note 1, art. 18(3).
- ⁹ Stella Mukasa & Anne Gathumbi, *HIV/AIDS, Human Rights, and Legal Services in Uganda: A Country Assessment* at viii, Open Society Initiative for East Africa (2008) [hereinafter *HIV/AIDS, Human Rights, and Legal Services in Uganda*].
- ¹⁰ African Charter, *supra* note 1, 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."); African Charter, *supra* note 1, art. 16(1) ("Every individual shall have the right to enjoy the best attainable state of physical and mental health."); and African Charter, *supra* note 1, 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.").
- ¹¹ Human Rights Committee, *General Comment 6: The right to life* (16th Sess., 1982), U.N. Doc. HRI/GEN/1/Rev.1 at 6 (1994) at para 5, available at: [http://www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/84ab9690ccd81fc7c12563ed0046fae3?Opendocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/84ab9690ccd81fc7c12563ed0046fae3?Opendocument) [hereinafter HRC Gen. Comm. 6].
- ¹² African Charter, *supra* note 1, arts. 2 and 3.
- ¹³ World Health Organization, *Maternal Mortality: The Measurement Challenge*, available at: http://www.who.int/reproductive-health/publications/maternal_mortality_2000/challenge.html ("... the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.").
- ¹⁴ Economic, Social and Cultural Rights Committee, *General Comment 14, The Right to the Highest Attainable Standard of Health*, para 52 (22nd Sess., 2000) U.N. Doc. HRI/GEN/1/Rev.5 (2001), available at: [http://www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/40d009901358b0e2c1256915005090be?Opendocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/40d009901358b0e2c1256915005090be?Opendocument). See, e.g., *CEDAW Committee Concluding Observations: Belize*, para. 56, U.N. Doc. A/54/38 (Jan. 7, 1999); *Colombia*, para. 393, U.N. Doc. A/54/38 (Apr. 2, 1999); *Dominican Republic*, para. 337, U.N. Doc A/53/38 (May 14, 1998); *Madagascar*, para. 244, U.N. Doc A/49/38, (Dec. 4, 1994).
- ¹⁵ HRC Gen. Comm. 6, *supra* note 11, para. 5.
- ¹⁶ Statement by Paul Hunt, Special Rapporteur on the Right to the Highest Attainable Standard of Health to the United Nations General Assembly (Oct. 19, 2006), available at: www2.essex.ac.uk/human_rights_centre/rth/docs/oral%20remarks%20of%20Paul%20Hunt%20GA%202006.doc.
- ¹⁷ UNITED NATIONS, MILLENNIUM DEVELOPMENT GOALS Goal 5, "Improve Maternal Mortality", [hereinafter Millennium Development Goal 5], available at www.un.org/millenniumgoals/index.html. See also *Beijing Declaration and the Platform for Action, Fourth World Conference on Women*, Beijing, China, Sept. 4-15, 1995, U.N. Doc. A/CONF.177/20, art. 107(i), (1995), available at <http://www.un.org/esa/gopher-data/conf/fwcw/off/a--20.en> (Countries should strive to effect significant reductions in maternal mortality by the year 2015: a reduction in maternal mortality by one half of the 1990 levels by the year 2000 and a further one half by 2015. Countries with the highest levels of mortality should aim to achieve by 2005 a maternal mortality rate below 125 per 100,000 live births and by 2015 a maternal mortality rate below 75 per 100,000 live births.); *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5-13, 1994, U.N. Doc. A/CONF.171/13/Rev.1, para. 8.21 (1995), available at www.un.org/popin/icpd/conference/offeng/poa.html.
- ¹⁸ Uganda Ministry of Health, National Health Policy 1999, para. 2.4.
- ¹⁹ *Id.*
- ²⁰ News Release, World Health Organization (WHO), *Uganda's First Lady Launches Road Map to Accelerate Reduction of Maternal and Neonatal Mortality and Morbidity* (Nov. 24, 2008), available at: <http://www.whouganda.org/news%20safe%20motherhood.asp>.
- ²¹ Uganda Delegation, *Statement to 42nd Session of the Commission on Population and Development* at 3, (Apr. 1 2009), available at: www.un.org/esa/population/cpd/cpd2009/Country_Statements/Uganda.pdf.
- ²² Ministry of Health & Macro International Inc., *Uganda Service Provision Assessment Survey 2007* at 107 (Aug. 2008) [hereinafter 2007 USPAS].
- ²³ *Id.*
- ²⁴ Uganda Human Rights Commission, *10th Annual Report to the Parliament of Uganda of the Uganda Human Rights Commission* at 59, (2007), available at http://www.uhrc.ug/pub_details.php?item=14 [hereinafter Uganda Human Rights Commission 10th Annual Report].
- ²⁵ *Id.* at 60.
- ²⁶ 2007 USPAS, *supra* note 22, at 108.
- ²⁷ Uganda Human Rights Commission 10th Annual Report, *supra* note 24, at 62.

²⁸ Uganda Bureau of Statistics, *Uganda Demographic and Health Survey 2006* at 121, (Aug. 2007) [hereinafter 2006 UDHS]. 94% of women aged 15 – 49 who had a live birth in the five years preceding the survey had made at least one visit to a clinic to receive [ANC], 42 percent had made two or three visits, and 47 percent made four or more visits.

²⁹ 2006 UDHS, *supra* note 28, at 121.

³⁰ 2007 USPAS, *supra* note 22, at 108.

³¹ *Id.* at 114.

³² *Id.* at 123.

³³ *Id.*

³⁴ *Id.*

³⁵ *Id.*

³⁶ *Id.*

³⁷ *Id.* at 126.

³⁸ *Id.* at xxvii.

³⁹ *Id.*

⁴⁰ *Id.* at 129.

⁴¹ *Id.* at 131.

⁴² *Id.* at 22. (The government of Uganda has eliminated user fees or cost sharing in all government health units. However, user fees are still charged for patients who access private wings of government hospitals and other private health care facilities.).

⁴³ Madinah Tebajjukira, *Mulago Hospital's Pathetic Condition Shocks Parliamentarians*, New Vision (16 Mar. 2009).

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ Sorious Samura, *Addicted to Aid*, BBC News (21 Nov. 2008), available at <http://news.bbc.co.uk/2/hi/programmes/panorama/7738297.stm>.

⁴⁸ 2006 UDHS, *supra* note 28, at 68. The contraceptive prevalence rate (the proportion of currently married women age 15-49 that are using *any* contraceptive method (modern or traditional) in Uganda is only 24 percent. *Id.*

⁴⁹ *Id.* at 88.

⁵⁰ *Id.* at 74. Modern contraceptive measures include: female and male sterilization, the pill, intrauterine device, injectables, implants, male condom, female condom, lactational amenorrhoea (LAM), and emergency contraception. Traditional methods include rhythm method (periodic abstinence) and withdrawal. *Id.* at 65.

⁵¹ 2007 USPAS, *supra* note 22, at 99.

⁵² 2006 UDHS, *supra* note 28, at 74.

⁵³ *Id.*

⁵⁴ *Id.* at 75.

⁵⁵ According to the 2007 USPAS, while the majority of facilities that provide contraceptive methods had them in stock on the day of the survey, “less than half of facilities in the Kampala and West Nile regions had each method they provide available on the day of the survey. 2007 USPAS, *supra* note 22, at 92.

⁵⁶ According to the 2007 USPAS, “[o]nly 23 percent of facilities offering temporary family planning have all items (including privacy, individual client cards, written guidelines, and visual aids) to support quality counselling This is principally because many facilities lack individual client cards and written family planning guidelines.” *Id.*

⁵⁷ While the vast majority of women surveyed by the 2006 UDHS had heard about family planning on television, video, film, radio or in a newspaper or magazine, women living in rural areas and women who have no education were less likely to be exposed to family planning messages, and only four percent of women who were not users of family planning and were targeted by family planning outreach programs were reached by field workers to discuss family planning. Furthermore, “only 12 percent of nonusers visited a health facility and were spoken to about family planning. Altogether, 86 percent of nonusers were not contacted about family planning through either of these two mechanisms in the 12 months preceding the survey. 2006 UDHS, *supra* note 28, at 80-81.

⁵⁸ According to the 2007 USPAS, only nine percent of facilities that provide intra-uterine devices (IUD) as a method of contraception had all the associated equipment available for removal and insertion, and satisfied the USPAS criteria, which include “all infection control items, visual privacy, an examination bed/table, an examination light, and” the IUD.” 2007 USPAS, *supra* note 22, at 97.

⁵⁹ Republic of Uganda, *Penal Code Act (CAP 106), Revised Edition*, 1984.

⁶⁰ See, e.g., CEDAW Committee Concluding Observations: Burundi, 02/02/2001, U.N. Doc. A/56/38, para. 61; Madagascar, 12/04/94, U.N. Doc. A/49/38, para. 244; Morocco, 12/08/97, U.N. Doc. A/52/38/Rev.1, para. 68; Namibia, 12/08/97, Zimbabwe, 14/05/98, U.N. Doc. A/53/38, para. 159; Belize, 01/07/99, U.N. Doc. A/54/38, para. 56; Colombia, 04/02/99, U.N. Doc. A/54/38, para. 393; Dominican Republic, 14/05/98, U.N. Doc. A/53/38, para. 337; Chad, 24/08/99, U.N. Doc. CRC/C/15/Add.107, para. 30. See, e.g., CRC Committee Concluding Observations: Chad, 24/08/99, U.N. Doc. CRC/C/15/Add.107, para. 30; Colombia, 16/10/2000, U.N. Doc. CRC/C/15/Add.137, para. 48; Guatemala, 09/07/2001, U.N. Doc. CRC/C/15/Add.154, para. 40; Nicaragua, 24/08/99, U.N. Doc. CRC/C/15/Add.108, para. 35; Nicaragua, 20/06/95, U.N. Doc. CRC/C/15/Add.36, para. 19. See, e.g., ICESCR Committee Concluding Observations: Cameroon, 08/12/99, U.N. Doc. E/C.12/1/Add.40, para. 25; Mauritius, 31/05/94, U.N. Doc. E/C.12/1994/8, para. 15; Senegal, 24/09/2001, U.N. Doc. E/C.12/1/Add.62, para. 26. See Center for

Reproductive Rights (CRR)(ed.), *Bringing Rights to Bear*, 145-153 (Center for Reproductive Rights 2002), available at www.reproductiverights.org/pub_bo_tmb.html.

⁶¹ African Charter, *supra* note 1, arts. 2,3,18(3); Maputo Protocol, *supra* note 5, art.2(1).

⁶² Susheela Singh et al., *Unintended Pregnancy and Induced Abortion in Uganda: Causes and Consequences* at 2-3, Guttmacher Institute, (2006) [hereinafter *Unintended Pregnancy and Induced Abortion in Uganda*].

⁶³ New Vision, *Abortion Kills 1,200 Women Every Year*, (14 Sept. 2007) available at <http://allafrica.com/stories/200709150045.html>.

⁶⁴ *Id.*

⁶⁵ *Unintended Pregnancy and Induced Abortion in Uganda*, *supra* note 62, at 2.

⁶⁶ Gabriel Jagwe-Wadda, Ann M. Moore, Vanessa Woog, *Abortion Morbidity in Uganda: Evidence from Two Communities* at 5, Guttmacher Institute (2006), available at: <http://www.guttmacher.org/pubs/or26.pdf>.

⁶⁷ *Id.* at 6.

⁶⁸ New Vision, *Abortion Kills 1,200 Women Every Year*, (14 Sept. 2007) available at <http://allafrica.com/stories/200709150045.html>.

⁶⁹ *Unintended Pregnancy and Induced Abortion in Uganda*, *supra* note 62, at 16.

⁷⁰ Maputo Protocol, *supra* note 4, art. 14(1)(d).

⁷¹ *Id.* art. 14(1)(d)(e).

⁷² CEDAW Committee, *General Recommendation 24: Women and Health*, paras. 6, 18 (20th Sess., 1999), U.N. Doc. HRI/GEN/1/Rev.5 (2001), available at <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm>. See, e.g., CEDAW Committee *Concluding Observations: Rwanda*, 09/05/96, U.N. Doc. A/51/38, para. 321; *Uganda*, 31/05/95, U.N. Doc. A/50/38, para.322; *Namibia*, 12/08/97, U.N. Doc. A/52/38/Rev.1, Part II, para.79.

⁷³ AVERT, *HIV and AIDS in Uganda*, available at: <http://www.avert.org/aidsuganda.htm>; Stella Mukasa & Anne Gathumbi, *HIV/AIDS, Human Rights, and Legal Services in Uganda: A Country Assessment* at vii, Open Society Initiative for East Africa (May 2008) [hereinafter *HIV/AIDS, Human Rights, and Legal Services in Uganda*].

⁷⁴ 2007 USPAS, *supra* note 22, at 173.

⁷⁵ *Id.*; AVERT, *HIV and AIDS in Uganda*, *supra* note 73.

⁷⁶ UNAIDS, *2008 Report on the Global AIDS Epidemic* at 41, available at: <http://viewer.zmags.com/publication/ad3eab7c/ad3eab7c/2> [hereinafter 2008 UNAIDS Report].

⁷⁷ Uganda Delegation, Statement to 42nd Session of the Commission on Population and Development at 3, Apr. 1 2009, available at http://www.un.org/esa/population/cpd/cpd2009/Country_Statements/Uganda.pdf.

⁷⁸ 2008 UNAIDS Report, *supra* note 76, at 42.

⁷⁹ UNICEF, Uganda, Country Statistics, available at:

www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp [hereinafter UNICEF Uganda Country Statistics].

⁸⁰ International News, *Ugandan Parliament Considers Bill That Would Require HIV Status Disclosure, Provide some Protections to HIV-Positive People* (Dec. 15, 2008).

⁸¹ AVERT, *HIV and AIDS in Uganda*, available at: <http://www.avert.org/aidsuganda.htm>.

⁸² *Id.*

⁸³ For instance, the proportion of sexually active Ugandans who reported having had two or more sexual partners in the previous 12 months increased from two to four percent between 2000-01 and 2004-05 among women and from 25 to 29 percent among men. *Id.*

⁸⁴ Lawrence K. Altman, *U.S. Blamed for Condom Shortage in Fighting AIDS in Uganda*, N.Y. Times, August 30, 2005.

⁸⁵ 2006 UDHS, *supra* note 28, at 121.

⁸⁶ 2007 USPAS, *supra* note 22, at 184.

⁸⁷ *Id.*

⁸⁸ *Id.* at 190.

⁸⁹ Swizen Kyomuhendo & Joseph Kiwanuka, *Access to Care, Treatment and Sexual and Reproductive Health Rights Needs of HIV Positive Women in Masindi and Busia Districts*, at 8 (Uganda, Jun. 2007) [hereinafter *Access to Care, Treatment and Sexual and Reproductive Health Rights Needs of HIV Positive Women*].

⁹⁰ *Id.*

⁹¹ 2007 USPAS, *supra* note 22, at 190.

⁹² *Access to Care, Treatment and Sexual and Reproductive Health Rights Needs of HIV Positive Women*, *supra* note 88 at iv.

⁹³ African Charter, *supra* note 1, art. 5 (“Every individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status. All forms of exploitation and degradation of man particularly slavery, slave trade, torture, cruel, inhuman or degrading punishment and treatment shall be prohibited.”).

⁹⁴ African Charter, *supra* note 1, art. 16(1) (“Every individual shall have the right to enjoy the best attainable state of physical and mental health.”); *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.”).

⁹⁵ *Id.* arts. 2, 3, 18(3).

⁹⁶ Children’s Charter, *supra* note 2, art. 27.

⁹⁷ *Id.* art. 21.

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- ⁹⁷ Maputo Protocol, *supra* note 4, art. 3(4).
- ⁹⁸ *Id.* at 294.
- ⁹⁹ 2006 UDHS, *supra* note 28, at 289.
- ¹⁰⁰ *Id.* at 291.
- ¹⁰¹ *Id.* at 292.
- ¹⁰² Joyce Mulama, Developing Stronger Protection Against Gender-Based Violence, Inter Press Service News Agency (Apr. 18, 2009) available at <http://www.ipsnews.net/news.asp?idnews=46550>.
- ¹⁰³ *Id.*
- ¹⁰⁴ *HIV/AIDS, Human Rights, and Legal Services in Uganda*, *supra* note 73, at vii.
- ¹⁰⁵ *Id.*
- ¹⁰⁶ *Access to Care, Treatment and Sexual and Reproductive Health Rights Needs of HIV Positive Women*, *supra* note 88, at 19.
- ¹⁰⁷ Sylvia Rowley, *HIV and women's rights in Uganda: why a new law would hurt women* (Jan. 3, 2009), available at: <http://www.opendemocracy.net/blog/email/sylvia-rowley/2009/03/01/hiv-and-womens-rights-in-uganda-why-a-new-law-would-hurt-women>.
- ¹⁰⁸ *Access to Care, Treatment and Sexual and Reproductive Health Rights Needs of HIV Positive Women*, *supra* note 88, at 20.
- ¹⁰⁹ *Id.* at 22.
- ¹¹⁰ *Draft HIV and AIDS Prevention and Control Bill, 2008*, on file with the Center for Reproductive Rights.
- ¹¹¹ Shelia Naturinda, *Bill to force spouses to reveal HIV status*, Kampala News (Dec. 12, 2008), available at: <http://www.monitor.co.ug/artman/publish>.
- ¹¹² Evelyn Lirri, *People living with AIDS Criticize HIV Bill*, Monitor online (Oct. 20, 2008).
- ¹¹³ *Draft HIV and AIDS Prevention and Control Bill, 2008* at art. 41. (“(1) A person who intentionally transmits or attempts to transmit HIV and AIDS to another person commits an offence of intentional transmission of HIV and AIDS and shall be liable on conviction to two years imprisonment or to a fine not exceeding fifty currency points or to both. (2) No person shall be convicted of an offence under subsection (1) if: (a) the person alleged to have committed the offence was not aware of being infected with HIV and AIDS at the time of committing the act which is the result of the complaint, (b) the other person was aware of the HIV and AIDS status of the accused and the risk of infection and he or she voluntarily accepted this risk; (c) the alleged transmission or attempted transmission was through sexual intercourse and a condom or other reliable protective measure was used during penetration; (d) the other person was already infected with HIV and AIDS at the time of the alleged transmission or attempted transmission.”).
- ¹¹⁴ *Draft HIV and AIDS Prevention and Control Bill, 2008* at art. 15.
- ¹¹⁵ *Id.* See also Anthony Bugembe, *AIDS Activists Reject Bill*, The New Vision (Oct 28, 2008), available at: <http://www.aegis.com/news/nv/2008/NV081020.html>
- ¹¹⁶ Global Health Reporting.org, *Ugandan Parliament Considers Bill that Would Require HIV Status Disclosure, Provide Some Protections to HIV-Positive People* (Dec. 15, 2008), at www.globalhealthreporting.org/article.asp?DR_ID=56071.
- ¹¹⁷ According to Article 7, persons convicted of drug abuse or in possession of a hypodermic instrument associated with drug abuse, persons convicted of sexual offences, persons convicted of offences involving lewdness or prostitution are also subject to mandatory HIV testing. *Draft HIV and AIDS Prevention and Control Bill, 2008* at art. 7. Furthermore, Article 13 of the draft Bill lists the circumstances under which consent to an HIV/AIDS test may be dispensed, and indicates that “[c]onsent to an HIV or AIDS test may be dispensed with where it is unreasonably withheld; or in an emergency due to grave medical or psychiatric condition and the medical practitioner reasonably believes that such a test is clinically necessary or desirable in the interest of that person, the medical practitioner may carry out such test.” *Id.* at art. 13.
- ¹¹⁸ Office of the U.N. High Comm’r for Human Rights (OHCHR) and the Joint U.N. Programme on HIV/AIDS (UNAIDS), *International Guidelines on HIV/AIDS and Human Rights: 2006 Consolidated Version*, U.N. Doc HR/PUB/06/9, Sales No. E.06.XIV.4 at para. 105 (2006).
- ¹¹⁹ *Id.* at para. 114.
- ¹²⁰ *Id.* at para. 96.
- ¹²¹ *Id.* at para. 105.
- ¹²² Maputo Protocol, *supra* note 4, art. 4(h).
- ¹²³ Russell Armstrong, *Mandatory HIV Testing in Pregnancy: Is There Ever a Time?*, 8 Dev. World Bioethics 1, 3 (Apr. 2008).