AN INTERSECTIONAL FEMINIST ANALYSIS OF THE SEXUAL REPRODUCTIVE HEALTH AND RIGHTS LEGAL AND POLICY FRAMEWORK IN UGANDA

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I. Introduction

Sexual and reproductive health and rights (SRHR) issues feature significantly in Uganda's legislative and policy agenda. The legal and policy framework exists to cure a range of sexual and reproductive health inequities, and to govern sexual behavior and conduct. This is achieved through a variety of means including the creation of criminal sexual offenses and licensing systems around goods and services. These forms of mediation and regulation build upon underlying assumptions about sex and sexuality that frequently amplify inequalities on the basis of age, gender, tribe, religion, or social class and sexual orientation. Thus, despite notable policy and fiscal investments in the area, there are still obstacles to realization of SRHR in the country.

International and regional developments offer strong cross-references to measure Uganda's progress on its commitments to SRHR advancement. Uganda is a state party to a range of international and regional treaties that articulate state party obligations in relation to sexual and reproductive health. The government of Uganda strongly references these instruments in its own legal and policy framework which defines SRHR as

> *...a state of complete physical, mental, and social wellbeing in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so.*[1]

The definition of sexual and reproductive health put forward at the global stage centers the liberal principle of autonomy, acknowledging that choices about sexual activity go to the heart of identity and relationships to and use of our bodies. The term bodily autonomy is "preferred when referring to the freedom to act upon choices made by a person with decision-making capacity which relates to the human body".[2] Thus the relationship between the state and the body takes center stage when thinking about autonomy as liberty. The body often symbolizes, in law, the private: that which is treated as foundational for the individual self, with the private being a protected sphere of individual freedom and responsibility. In pursuing autonomy, one shapes one's life; one constructs its meaning, thus the autonomous person gives meaning to his life.[3] The term is used alongside "bodily integrity" which means the recognition, respect, and non-violation of a person's parameters and boundaries in relation to what can be done to their body. Together these frameworks constitute the foundations of feminist legal theory when applied to SRHR, yet such important concepts are not clearly defined in existing legislation in Uganda.

Gender intersects with other social factors to drive health inequities.[4] The World Health Organization asserts that influence of legal and policy frameworks and gender norms are significant social determinants of sexual and reproductive health.[5] Gender is a social construction—influencing, and in turn influenced by, the distribution of power and resources, divisions of work and labour, distinctions between production and reproduction, and expectations and opportunities available to all people in all societies.[6] A feminist legal analysis takes into account how the law is applied to advance or inhibit full participation in public and private life on the basis of gender. Such an analysis is necessary to surface how gender inequalities drive inequities in health and wellbeing.

The two basic requirements of autonomy are agency (the capacity for intentional action) and liberty (independence from controlling influences).[7] Many choices about the body involve intimate actions, as in the case of sexual activity. Other bodily choices also lead to inherently personal actions, such as undergoing medical treatment, causing bodily harm or death, transforming the appearance of the body, or using the body in unconventional ways.[8] Thus, through a feminist lens, the personal is political. The demarcation of public and private life within society is, in itself, 'an inherently political process that both reflects and reinforces power relations.'[9] The private is public for those for whom the personal is political. The feminist critique of the public-private distinction challenges the distinction as an artificially constructed line, drawn by the state, which ensures that the contexts in which women and girls are most oppressed are positioned on the wrong side of the line thus legitimating such oppression.[10] Feminist analysis offers tools to interrogate hierarchies and systems of power embedded within the law, and to surface the insidious modes of power, control, and exclusion that promote or hinder full sexual citizenship on the basis of sex or gender.

This essay undertakes an intersectional feminist analysis of key SRHR-related laws and policies in Uganda, gauging gaps in legal and policy frameworks relating to the State's obligations and commitments under international human rights. The regulation of sexual and reproductive choices will be unpacked through three lenses. First is an interrogation of the state's power to regulate and the justifications that inform such interventions. Second, we look at where and when the state chooses to intervene; whether the decision or act in question falls within the private or public sphere of autonomous choice. Lastly, we weigh such interventions against individual dignity and right to equal treatment before the law. The analysis concludes by developing recommendations in response to the gaps in existing SRHR-related laws and policies.

II. THE SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR) LEGAL AND POLICY FRAMEWORK IN UGANDA

International and regional laws apply to Uganda's legal context by virtue of the country's accession to these instruments,[11] for example the International Covenant on Economic Social and Cultural Rights (1966), the Convention on Elimination of all forms of Discrimination against Women (1981), the Convention on the Rights of the Child (1989), the African Charter on Human and Peoples Rights (1981), and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, better known as the Maputo Protocol (2003). A limited range of soft law may also be applied within the Ugandan context based on its adoption through case law and similar jurisprudence. For example, the Yogyakarta Principles reflect the application of the core human rights contained in traditional treaties and translate their application to sexual rights with particular regard to sexual orientation, gender identity, and expression (SOGIE).[12] Within this collective human rights framework, the freedom to determine how to live one's own life is prioritized.

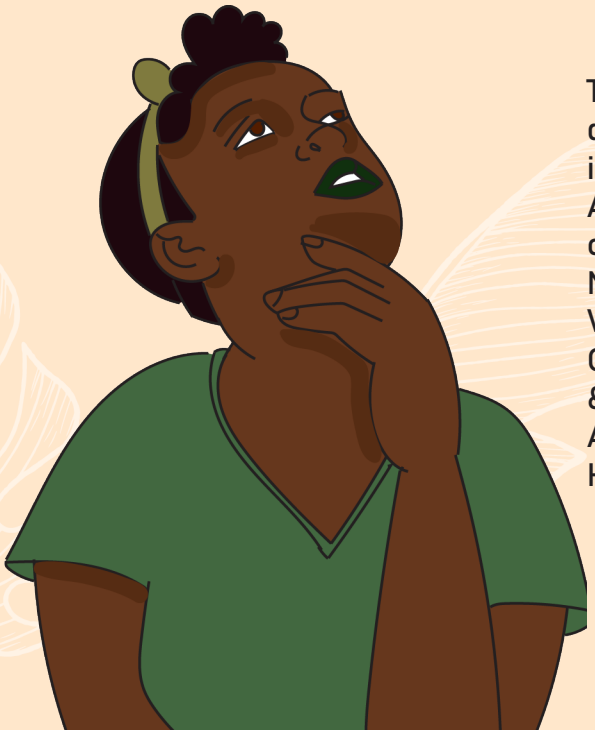
Grounded in the 1995 Constitution, the laws of Uganda offer a foundation for the protection and advancement of sexual and reproductive health and rights. The state intervenes in sexuality and reproduction by means of regulation using civil or criminal law to regulate individual choices on sexual autonomy like polygyny, prostitution, sexual relations between adults of the same sex, or adults with kinship. Reproductive autonomy – including access to reproductive health goods and services, access to technology for reproductive assistance, and abortion – are also regulated. This regulation of sexuality and reproduction through civil or criminal law is justified by two principles: the need to protect others from harm, and the need to protect public morality and dignity.

The Constitution (1995) contains foundational principles that protect autonomous decision-making, a progressive approach anchored in equality and non-discrimination as its foundational principles. Under Article 21, this covers all persons regardless of "sex, race, colour, ethnic origin, tribe, birth, creed or religion, social or economic standing, political opinion or disability." It also expressly prohibits "different treatment to different persons attributable only or mainly to their respective descriptions." This

grand norm is, however, self-contradictory in some ways. Regulation of sexual autonomy through criminal and civil legislation is significantly infused with paternalistic and moralistic restrictions that impact various groups. It imposes an obligation for individuals to adapt their behaviour to avoid any offense being caused to others. Yet the causing of offense to others by activities undertaken solely in a private realm does not justify intrusion into that private realm by the state. Thus, state interference merely on the basis of distinct characteristics like sexual orientation or gender identity or expression can be seen as illegitimate or unnecessary.

Significant portions of the SRHR legal and policy framework are informed by paternalistic and moralistic views of sexuality steeped in colonial interpretations of African sexualities.[13] Adopted in the 1950s, the Penal Code Act (PCA) Cap. 120 is among the oldest legislation in the country. It builds upon the state power and responsibility to protect from harm, grounding the understanding that the 'only purpose for which power can rightfully be exercised over any member of a civilised community is to prevent harm to others'.[14] Admittedly, the PCA contains a number of outdated provisions and ingredients constituting certain offences that do not reflect evolving social attitudes, values, and sexual practices.[15] However, more recent articulations of the rationale for regulation of sexual autonomy affirm the state's control over sexuality while seeking to expand its protective role with regard to sexual violence and punishment of sexual offenders.[16]

The prohibition of same sex marriage under Article 31A, the prohibition of abortion except in certain restrictive circumstances under Article 22(2), and the criminalisation of prostitution are some other well-known unjustifiable restrictions on sexual and reproductive autonomy. And although the Government of Uganda ratified the Maputo Protocol on the rights of women, it did so with reservation to Article 14(2)(c) on reproductive health and abortion 'in cases of sexual assault, incest, rape and when pregnancy endangers a mother's mental and physical well-being'. For social and political reasons, comprehensive abortion care is not included in national responses for maternal healthcare improvement in Uganda.[17]



The domestic legal and policy framework builds upon developments at international and regional levels and includes the Prohibition of Female Genital Mutilation Act 2010, and the Domestic Violence Act 2010, among others. The policy framework considered includes the National Plan of Action for Sexual and Gender Based Violence and Violence Against Children, National Comprehensive Condom Programming Strategy & Implementation Plan 2020-2025, the National Adolescent Health Policy 2000 and the Adolescent Health Policy Guidelines and Service Standards 2012,

among others. A comprehensive list of resources for the policy framework is available on the Ministry of Health website.[18] Notably, policies that directly address what are considered culturally sensitive subjects are not publicly available on those sites; for example, transgender and MSM-specific progressive policies remain hidden from public view. Such practices restrict fulfilment of SRHR for sexual and gender diverse communities as discussed here.

III. THE EXTENT TO WHICH GENDER LENS AND FEMINIST PRINCIPLES ARE INFUSED IN THE DESIGN AND IMPLEMENTATION OF SRHR LAWS AND POLICIES IN UGANDA

The analysis focuses on two interconnected components of bodily autonomy: sexual autonomy and reproductive autonomy. Decisions that come into the ambit of sexual autonomy are linked to the ability to have a satisfying and safe sex life – such as choice of partner, sexual habits, and access to accurate and appropriate information about sexual health. Reproductive autonomy, on the other hand, has to do with the capability to reproduce, and the freedom to decide if, when, and how often to do so.[19] Can a legitimate interest be put forth to support how the Ugandan state regulates autonomous choices in these realms, whether to protect from harm or to advance dignity?

Several of the interventions in Uganda's legal and policy framework seek to address health inequities by increasing the accessibility of sexual health through the manipulation of power. The social-political structures of power define what is "acceptable" sexual behavior for men and women in our societies. This creates a deeply entrenched and value-laden system that places sexual expression on a scale of acceptable/unacceptable, natural/unnatural, and good/bad.[20] What emerges is a sexual hierarchy that further oppresses individuals/groups based on distinct characteristics.[21] In analyzing the state's exercise of this power, feminist legal critique is directed at the justifiable exercise or failure to exercise that power to intervene. This means finding a balance between our own sphere of decision and action in the context of choices about our bodies (linked to autonomy) and the state's need for regulation of harmful or degrading practices.

Consent and autonomy are crucial when drawing a public-private distinction and the exercise of liberty. The capacity for intentional action (agency) and independence from controlling influences (liberty) are two prongs of autonomy. For instance, performance of an intimate action behind closed doors does not provide blanket immunity from state interference, nor even an assumption of non-interference, unless what ensues is a private choice by all parties.[22] The dignity element serves a dual role: 'dignity as empowerment' (when it champions autonomous choice) and 'dignity as constraint' (when it restrains autonomous choice). Ideally, the law ought to respect irrational choices provided that decision-making capacity exists, but this is not consistently applied to sexual and reproductive choices. Dignity is closely linked to equality, reminding us that all human beings are entitled to equal respect by virtue of their membership to the social group named human. This joins with privacy as a dignity element to fully justify the value of a private sphere of action and calls for a revision of the public-private distinction in a manner that sometimes requires state interference to enable the realization of the rights to equality and liberty.[23]

Debates on the parameters of consent within Ugandan law are ongoing as evidenced in the recent national debates on comprehensive sexuality education and also the sexual offences bill.[24] Issues of consent, while complex, also come into play when defining the private sphere. Are adult sex workers capable of exercising the autonomous choice to sell their services in exchange for money? Ugandan law responds in the negative, stripping these individuals of their agency over sexual practices. The legal and policy framework takes a highly restrictive approach to consent, autonomy, and pleasure – e.g. sex toys are subject to confiscation under import customs laws. Such restrictions contravene regional and international frameworks including the WHO Consolidated Guideline on Self-Care Interventions for Health: Sexual and Reproductive Health and Rights.[25]

a. Gaps and missing links in the current SRHR legal and policy framework

Intersectionality, a concept popularised by Prof. Kimberlé Crenshaw, surfaces how different social identities like race, gender, class, and sexuality intersect and inform each other in "interlocking systems of oppression".[26] Intersectionality is a way of understanding the divisions and hierarchies of social life as they are used in various ways rather than a reference to a single theoretical framework. This analytical framework aligns with postcolonial and post-structural ways of thinking about power relations,[27] and has aided African feminists in dismantling the unitary notion of 'women' to include various co-constructed identities that surface how race, social class, and belonging shape relative power. It has also motivated the inclusion of other gendered identities (sexual minorities, trans and gender nonconforming people, and some men) into feminist thinking.

Using this frame of analysis surfaces significant gaps within the SRHR legal and policy framework in Uganda, the largest being that foundational concepts like bodily autonomy and body integrity are not clearly defined in existing legislation. Both these concepts are core tenets of sexual and reproductive health and rights and offer protections for more vulnerable groups such as people with disabilities and the elderly. Feminist activists are pushing for these definitions to be introduced in existing and future legislation to clarify their usage.[28] Other issues that emerge for feminist legal activism include comprehensive sexuality education, regulation of sexual and reproductive technologies, gaps around legislation of surrogacy, women and girls who are vulnerable to exploitation, access to assistive reproduction processes like IVF, access to hormone replacement therapy, and regulation of sexual harassment beyond the workplace.

Non-discrimination within SRHR

Conversion therapy practices, for instance, are increasingly being named as an insidious pattern that individuals are faced with on the basis of sex. The term "conversion therapy" is widely used to describe the process of cis-gender, hetero-normative indoctrination – that is, attempting to change, suppress, or divert one's sexual orientation, gender identity or gender expression.[29] The term has its history in western psychiatry, which pathologises sexual and gender diversity, and sets the stage for claims that people could be converted to cisgender heterosexuality through such "treatments." Although the position of psychiatry has long since changed – homosexuality was removed from the Diagnostic and Statistical Manual of Mental Disorders (DSM)-III-R in 1987 and from the International Classification of Diseases (ICD)-10 in 1992[30] – the stigmas surrounding homosexuality persist today and has resulted in the treatment of LGBTQ+ identities as pathologies in need of a cure.[31] Religion, combined with family and cultural pressures, seems to fuel the practice of "conversion therapy" in Uganda.[32]

Research on conversion therapy indicates that it is harmful and amounts to torture but there are still limited articulations within local activism that frame such practices as an SRHR issue and thereby politicizing it. Feminist legal activism is needed to empower communities to understand the human rights dimensions of this issue so that they can engage the state on its obligation to protect citizens from torture, cruel, inhumane, and degrading treatment.

Related to non-discrimination is the urgent need to push towards legal recognition and protection for trans, intersex, and non-binary individuals whose SRHR needs remain in a dire state. Uganda has been lauded in its fight against HIV; laws like the HIV Prevention and Control Act, 2015, and the National Strategic Plan on HIV/AIDS, which identify these groups as key populations.[33] Yet criminalization of SOGIE undermines agency and autonomy, pushing SRHR needs

into a dreadful state within this community. For instance, HIV prevalence rates among transgender women in Uganda stands at 50% [34]; that is, one in two trans women will contract HIV. The public health framework is failing to adequately respond to the comprehensive SRHR needs of these LGBTQ+ individuals because criminalization undermines their capacity as rights holders. Criminalization of gender diversity consists of laws that prescribe and punish petty offenses as well as cross-dressing, linking gender expression to impersonation.

Along with a broader interpretation of non-discrimination is the need to revisit restrictions on body modifications through surgery, including gender reassignment surgery. The state's legitimate role in regulating such activities depends entirely upon the contentious and erratic labelling of these choices as mental disorders, identity disorders, the result of sexual abuse, or an autonomous choice. Transgender people continue to be subject to legally prescribed state-enforced sterilization through the Registration of Persons Act, 2015 which incorporates a biomedical model to gender identity and expression. Strictly speaking, the law permits intersex children who undergo an operation to register a change in sex. This provision is sometimes read to exclude trans people who were definitely assigned a sex at birth, and who have virtually no access to gender affirming surgeries that the law seemingly sets up as a requirement for affirming trans autonomy. The establishment of a requirement for medical interventions as a basis for legal recognition has been found to be an egregious violation of the right to dignity and other SRHRs especially when such a requirement is established without corresponding forms of public health support. At present, many trans, intersex, and non-binary individuals rely on informal sources of SRHR information which are not acceptable, affordable, or accessible and therefore fail to realise the SRHR rights for this group.

Moreover, while medicalisation of the desire to modify the body has the potential to open doors to treatment, it arguably restricts a broader recognition of bodily autonomy.[35] The acceptance of gender dysphoria as a medical problem to be fixed by medical treatment may work in the favour of many transgender individuals in terms of access to healthcare and legal recognition but Thielen accurately notes that the group of people affected by trans-specific healthcare is much smaller than the group affected by trans pathologisation (which includes women in their diversity of gender expression i.e. butch, tomboy, or simply cis-women who may be read as masculine based on a range of socio-cultural interpretations). The labelling of certain desires relating to the body as 'identity disorders' represents a convergence of psychiatry, medicine, and law in restricting the bodily autonomy and integrity rights of a category of persons, perceived, perhaps, as deviants. This issue is at the crux of current trans feminist legal debates about the meanings of gender, and which seeks to articulate bodily autonomy within non-discrimination to ensure that such protections are expressly guaranteed. In this way,

feminist analysis is helping to repoliticize trans activism to challenge gender stereotypes and norms.

SRHR for persons living with disabilities also remains woefully inadequate. Current laws/policies mostly talk about persons with disabilities (PWDs) having the right to found a family but do not acknowledge the continued eugenic practices against PWDs in the SRHR realm. Surfacing these issues is central within non-discrimination to realise substantive equality which requires that the distinct sexual and reproductive health needs of particular groups, as well as any barriers that particular groups may face, are addressed.[36] For example, persons with disabilities should be able to enjoy not only the same range and quality of sexual and reproductive health services but also those they would need specifically because of their disabilities.

Further, reasonable accommodation must be made to enable persons with disabilities to fully access sexual and reproductive health services on an equal basis, such as physically accessible facilities, information in accessible formats and decision-making support, and states should ensure that care is provided in a respectful and dignified manner that does not exacerbate marginalization. The concept of "reasonable accommodations" means necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure persons with disabilities the enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms. Although this definition is included in the Persons With Disabilities Act in line with the Convention on the Rights of Persons with Disabilities, persons with disabilities do not have the same range, quality, and standard of free or affordable health care and programmes as provided to other persons in Uganda.

A major barrier for PWDs is access to appropriate and acceptable information as there are few healthcare personnel trained to effectively communicate and work with people with disabilities to better provide the required assistance and services. In order to be appropriately equipped to respond to the needs of people with disabilities, the training of healthcare personnel should go beyond simply communicating but also interacting and taking care of people with disabilities. The provision has been amended in line with Art 4 (1) (i) of CRPD. The state needs to tackle this problem through legislation and training to combat stereotypes, prejudices and harmful practices relating to persons with disabilities, etc., to ensure that people with disabilities have equal opportunities to enjoy their SRHR.

Feminist legal activism is needed to realise the non-discrimination protections within policy so that individuals are able to exercise fuller autonomy, access, protection over their sexual and reproductive needs especially for trans, intersex, and nonbinary individuals, as well as for people living with disabilities. Specifically, autonomy and reasonable accommodations demand urgent engagement.

Comprehensive sexuality education and the rights of the child (youth groups)

Despite well-documented challenges for SRHR among youth, the teaching of sexuality education in schools has been a controversial subject for over twenty years.[37] International human rights law explicitly recognizes the rights of children which are provided for in the Convention of the Rights of the Child (CRC), including the right to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. However, the law treats children like a monolith, creating paternalist restrictions, which always assume that children do not have the capacity to make decisions about their health.[38] Moral values are recognised as a basis for limiting the rights of children, within the CRC. In Uganda, values that seek to directly undermine the non-discrimination protection in the Constitution and other international human rights commitments have been incorporated into the National Comprehensive Sexuality Education (CSE) Policy (2018). Some institutions of learning, particularly private ones, have encoded into written and unwritten law, provisions that justify the penalising of pregnant students through expulsion and other forms of punishment, in contravention of existing provisions on non-discrimination. This grossly undermines the full realization of SRHR for young people, who constitute the majority of Uganda's population.

The main debate within such discussions is usually one of defining what is age-appropriate, a challenge that is left to the policy makers. Majority of the religious leaders vehemently rejected the policy, fuelled in part by homophobia and transphobia. The Ministry of Gender had allegedly stumbled on sexual and reproductive health books in more than 100 schools that included sexual orientation prior to banning the teaching of sexuality education in schools. In 2016, Parliament passed a resolution banning CSE. Such actions constitute retrogressive measures, which violate Uganda's international human rights commitments.

Uganda is finally on its way to ensuring that individuals and groups including adolescents and youth, have access to evidence-based information on all aspects of sexual and reproductive health, including maternal health, contraceptives, family planning, sexually transmitted infections and HIV prevention, safe abortion and post abortion care, infertility and fertility options, and reproductive cancers. This came following a four-year court battle in which civil society, led by the Center for Health, Human Rights, and Development (CEHURD), filed a suit to challenge the ban. In November 2021, the High Court in Kampala directed the Ministry of Education to quickly develop and implement the comprehensive sexuality education policy for school learners, thereby ending a 10-year wait.

Feminists at the forefront of SGBV activism have pointed out the need for definitions of "adolescent girl or young woman" to widen the scope of protection

to cater for other women who may not fall neatly into this categorisation but are penalised for pregnancy out of wedlock when still in school, particularly in tertiary institutions. They point out that defining adolescence by age alone has increasingly become contested, as scientific and psychological research has shown that some people begin adolescence earlier and finish later such that focusing on age alone renders others with different experiences invisible. There are proposals to add indicators on geographical area and level of education, as these are important contributing factors to pregnancy while in school.[39] This work is necessary as it links SRHR to other human rights, specifically the right to education, pointing out that it should be the prerogative of the student to decide when to take a break from school during pregnancy based on their health needs.

The developments around CSE are promising for the SRHR advocacy landscape as they draw a clear boundary with regard to retrogressive measures i.e. that the state cannot go backwards when it comes to SRHR. This is a crucial development within our local jurisprudence which must fuel our activism because the government of Uganda, along with routinely under-investing in health, also takes actions that erode the gains we have made. This is a concern that feminist legal activism must be vigilant about. Institutionally, the debate and the outcome affirm the active role that the judiciary can play in safeguarding the progress made on SRHR issues. At the same time, feminist legal and policy advocacy is needed to ensure that the Ministry of Education's interpretation of what is age-appropriate reflects the diverse realities of all Ugandan youth.

Self-care and healthcare financing (Universal Health Coverage – UHC)

Healthcare financing is a feminist legal and policy issue. Funding to the health sector has consistently remained lower than the required levels. Over the period between FY2016/17–FY2020/21, health sector allocations increased in nominal terms from UGX 1.827 trillion in FY2016/17 to UGX 2.736 trillion in FY2020/21. However, despite this nominal increase, government allocations to the health sector have remained lower than the Abuja Declaration target of 15% and have averaged 8.6% during FY 2016/17 and FY 2017/18 and projected to reduce to 6.20% of the total national budget in FY 2020/21.[40]

Moreover, there is no active well-funded social protection programme for most Ugandans. Within this context, PWDs and other marginalized groups are especially prone to abuse and unable to claim their right to bodily autonomy when exercising SRHR. Feminists are among the leading advocates pushing for universal health coverage (UHC) which refers to the state where all people have access to the highest standard of health services they need, when and where they need them, without financial hardship or discrimination and includes the full range of essential health services, from health promotion to prevention,

treatment, rehabilitation, and palliative care. Such a definition ensures quality and inclusion.

The ongoing conversations about self-care should aim to empower individuals with relevant information to take charge of their health, and to advocate for their entitlements within the healthcare system.

b. Recommendations on responding to the gaps in existing SRHR related laws and policies.

A feminist legal and policy framework on SRHR in Uganda is a fight for three things: autonomy, agency, and integrity. Making progress on SRHR requires comprehensive legal approaches, which utilise a multipronged approach incorporating litigation, legislative advocacy, and feminist consciousness-raising to respond to the gaps identified in the current legal and policy framework.

On the legislative front, the ongoing national law reform efforts offer an avenue to expand debates on autonomy and the state's legitimate interest to regulate. The East Africa Community Sexual and Reproductive Health Bill (2021) is another promising point of intervention for feminist movements in East Africa. The bill contains the most progressive pronouncements on sexual and reproductive health, incorporating provisions on equality and non-discrimination; it explicitly mentions SRH for persons living with disabilities and the elderly. It provides for menstrual health and hygiene, and emphasizes budgetary allocations for SRHR. These are core issues for feminist organizing around SRHR; the ongoing consultative processes are a unique opportunity to influence legislation that would, if successful, ultimately bind the government of Uganda to adopt progressive positions on bodily autonomy.

Activism is needed to expand access to information shaping the ideologies that mediate and interpret the type of information, sources, and uses of information about SRHR in Uganda. Arbitrary distinctions rooted in patriarchal cis-het hegemonies like the ones embedded in the definitions of sexuality, sexuality education, or discrimination must be resisted using the legal tools available. For instance, the court rightfully rejected as semantic an argument by a Ministry of Education official in favour of "sexuality education" but not "comprehensive sexuality education".

Social protection is a feminist SRHR issue. SRHR legal and policy frameworks recognise the influence of social determinants of health. In

Uganda, this is especially relevant for groups that are vulnerable or marginalized in the realization of SRHR. Specifically, the socio-economic dimensions that negatively shape SRHR outcomes for groups including youth, the elderly, people with disabilities, and key populations (KPs). State bodies like the Ministry of Education also recognise that even if HIV and other SRHR issues were addressed, youth unemployment would remain a driver for risky sexual practices among youth thus setting back the gains made (NSE 2018). Advocates working with KPs have also increasingly noted the need for socio-economic welfare to safeguard SRHR for marginalized groups. With chronic underfunding for the health sector, advocacy around national health insurance and UHC is a major advocacy issue for feminist legal advocacy.

Strategic litigation to expand legal protections is another avenue for intervention by feminist movements. Judicial tone and attitude play an important part in cases involving issues of sexual autonomy and human dignity. There is a limited scope of feminist jurisprudence to expand the interpretation of SRHR at national level. Organizations like CEHURD and Women's Probono Initiative (WPI) are among those using litigation to hold the state accountable for failing to protect women's SRHR rights. While these efforts are laudable, a wide-sweeping commitment to holding the state accountable for failing in its obligation to protect SRHR rights needs to extend to regional and international mechanisms. The Committee on the Elimination of Discrimination against Women (CEDAW), for instance, has the authority to hear individual complaints from state parties yet Ugandan feminist and SRHR movements have not engaged this body and others like it.

Shifting awareness around SRHR is no small task. Even when new information emerges, public understanding of these issues is slow to shift due to deeply ingrained cultural and religious beliefs. Feminist consciousness-raising is continuously needed to expose the relevance of decolonial approaches to law and legal advocacy. Intergenerational dialogues also serve as a bridge between generations of women, queer, and feminist activists helping to educate, expand, and support feminist networks that will be needed to carry on the work of dismantling systems of oppression. Unpacking shame and empowering individuals to become more self-aware in order to make autonomous choices is an important part of the feminist work that remains to be done to advance SRHR.

IV. CONCLUSION

Much work remains to remove gender assumptions and oppression from choices to cross the divide.[41] The feminist approach recognizes that a public-private distinction built firmly on concepts such as consent and autonomy can be valuable to everyone regardless of gender. Public interest in sexual and reproductive choices should be limited to circumstances where the rights of others, a lack of capacity, or dignity of the human species as a whole are in play. The current use of the criminal law to regulate reproductive choices, such as abortion, is unacceptable. In the words of activist Lindy West (2021), "all anti-choice politics does is to keep people trapped in poverty for generations. That's the goal. And if it wasn't the goal, they would spend their time and money on comprehensive sex education, free birth control, and free contraception." It is not justifiable for a person (especially women and sexuality- and gender-diverse groups) making a unique embodied autonomous choice to be regarded as blameworthy or criminal.

Changes in relevant laws do not always adequately reflect societal changes, nor offer sufficient protection against abuse. Thus, feminist intersectional advocacy must insist on protection against harm and abuse, non-discrimination, and protection of autonomy as underlying principles for legislative processes on SRHR. A clear movement position needs to be articulated for what sort of behavior the criminal law should and should not prohibit. The key to enhanced bodily autonomy must include capacity to consent and an awareness of any risks.

Any idea of public morality as a justification for state regulation of reproduction must be rejected.

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This technical brief was developed by Noah Mirembe Gabigogo under the auspices of the Joint Advocacy for SRHR program (JAS). Its publication was made possible by the Centre for Health Human Rights and Development (CEHURD) with financial support from the Swedish International Development Cooperation Agency (SIDA).

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