Violence Against Women and HIV Control in Uganda: A Paradox of Protection?

By Kim Thuy Seelinger*

I. Introduction

HIV disproportionately affects women in sub-Saharan Africa, where 60% of adults with HIV/AIDS are female.1 Of the 24.5 million HIV-positive people ages 15-49 years old in Sub-Saharan Africa, 59% (13.2 million) are women.2 The gender imbalance is particularly stark among infected people between ages 15-24, where a full 74% are women.3 In Uganda specifically, UNAIDS estimates that in 2007, 810,000 (5.4%) of Ugandan adults aged 15-49 had

---

* Staff Attorney and Clinical Instructor, Center for Gender and Refugee Studies, University of California, Hastings College of the Law. Thank you to Tsering Kheyap and Kelsey Kofford for their invaluable research and interest. I am also indebted to the many inspiring Ugandans — lawyers, community advocates, Parliamentarians, police officers — who took time to educate me about Uganda’s efforts to combat both gender-based violence and the HIV epidemic. I am similarly grateful to Professor Sofia Gruskin at the Harvard School of Public Health for her generous feedback early on. I thank Dr. David Bangsberg at Massachusetts General Hospital Center for Global Health and Harvard Medical School for making this research possible to begin with. Finally, I am beholden to Dr. Elvin Geng for affording me not only his HIV expertise but also his unflagging support in all things.


3. Id.
acquired HIV. Of these, 480,000 (59%) are women.

With women comprising a solid majority of cases of HIV infection in Uganda, the underlying causes for their vulnerability to HIV are of particular interest. For example, both public health and human rights observers have begun to explore the possibility of a two-way relationship between violence against women and HIV. Gender-based violence (GBV) has been linked to increased vulnerability to HIV infection in women for both physiological and social reasons. Whereas, in reverse, disclosure of HIV-positive status is also reported to result in various forms of violence against infected women — a troubling challenge which has decreased infected women’s ability to access critical healthcare services, according to both public health and human rights observers.

The Ugandan government has long been lauded for its remarkable transparency and engagement in the fight against HIV/AIDS. The HIV infection prevalence rate in Uganda peaked at an alarming 18% in 1992. The Ugandan government since set itself on a course of creative and aggressive HIV prevention and treatment strategies in the form of a variety of national policies and programs which enlisted civil society in efforts to reduce high-risk behaviors and stigmatization associated with the disease. It enjoyed admirable success during the 1990s, cutting the HIV prevalence dramatically to around 5% in 2001. Infection rates


5. Id.

6. “HIV” stands for “human immunodeficiency virus,” a retrovirus that infects and destroys the functioning of the cells of the human immune system and compromises a person’s ability to fight off disease and infection. It is transmitted through unprotected penetrative sex with an infected person, blood transfusion with contaminated blood, use of contaminated syringes, or from an infected mother to her child during pregnancy, childbirth, and breastfeeding. “AIDS” stands for “acquired immunodeficiency syndrome” and refers to the most advanced stages of HIV infection (marked by the occurrence of over 20 HIV-related infections or cancers, and the dropping of a person’s immune system below a baseline level.) If left untreated, the majority of HIV-infected people develop signs of HIV-related illness within 5-10 years. “HIV/AIDS” refers to the span between the virus itself and its fullest consequences. See UNAIDS “Fast facts about HIV” on HIV, prevention, and treatment, http://www.unaids.org/en/KnowledgeCentre/Resources/FastFacts/default.asp (last visited Mar. 29, 2010).


8. Id.
stabilized from 2002-2005. Unfortunately, Uganda experienced a slight increase in infection rates in 2006. An epidemiology review, published in 2009, indicates that the previously heralded decline in prevalence may have ended — infection rates have stabilized throughout most parts of the country, and even risen in a few.

Understanding that the HIV epidemic is far from over, the Ugandan government is now pursuing a legislative track to combat HIV/AIDS. The HIV/AIDS Prevention and Control Bill (2009) is currently under consideration in the Ugandan Parliament. Its protections should in theory benefit Ugandan women, given their disproportionately high infection rates. However, though the bill features many positive provisions regarding the provision of health services, the regulation of providers, and the prohibition of health status discrimination by public and private actors, it also contains key provisions that contravene international human rights norms and guidance regarding HIV policy. The unfortunate irony of these provisions is that they may actually contribute to increased violence and discrimination, which may in turn increase vulnerability to HIV infection or harm resulting from HIV-positive status — especially for women.

This article seeks to evaluate Uganda’s proposed HIV law as well as recent legislative measures targeting violence against women in its many forms. The article first summarizes the literature linking gender-based violence and HIV, and presents the major forms of violence against women experienced in Uganda today. It then analyzes Uganda’s HIV/AIDS Prevention and Control Bill (2009) currently under Parliamentary review, highlighting certain provisions which contravene international guidelines and human rights norms and which may negatively impact women. Finally, the article notes existing and pending laws that address gender-based violence linked to the rise of HIV infection in Ugandan women. It concludes that, if enforced meaningfully, legislation targeting GBV may incidentally promote prevention of HIV infection in cases of transmission through GBV (domestic violence, rape, female genital mutilation, etc) and minimize harm to women who are already HIV-positive. Unfortunately, the HIV/AIDS Prevention and Control Bill, in its current form, may not have the same cross-benefit. In fact,

9. Id.

insofar as the bill emphasizes deterrence of infection without sufficient regard to the gendered realities of transmission, it may be counter-productive and actually undermine women's human rights.

II. Violence Against Women and HIV

Article 1 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) defines gender-based violence as violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty.\(^{11}\)

The UN Declaration on the Elimination of Violence against Women, proclaimed by the UN General Assembly in its resolution 48/104 of 20 December 1993, further defines “violence against women” as including, *inter alia*:

(a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;

(b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;

(c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.\(^{12}\)

Delegates at the 2001 UN General Assembly Special Session on HIV/AIDS recognized the link between the safeguarding of women’s human rights and female vulnerability to HIV. They declared that the promotion of gender equality and the empowerment of women are “fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS” and that meaningful realization of human rights and fundamental freedoms is an “essential element in a global response to the


HIV/AIDS pandemic."\(^\text{13}\)


Women's subordination in the family and in public life is one of the root causes of the rapidly increasing rate of infection among women. Systematic discrimination based on gender also impairs women's ability to deal with the consequences of their own infection and/or infection in the family, in social, economic and personal terms.\(^\text{14}\)

A March, 2010, report released by UNAIDS reiterates the connection between gender inequality and HIV/AIDS:

The increased vulnerability of women and girls to HIV infection stems from biology and from social, economic, legal and cultural factors such as entrenched gender roles, unbalanced power relations, disproportionate burden of AIDS-related care and the occurrence, and societies' acceptance of, violence against women, including sexual coercion.\(^\text{15}\)

Increasingly, medical and human rights literature indicates that the relationship between gender-based violence and HIV infection may be a two-way street. Simply put, GBV increases women's risk of HIV infection due to both physiological and social reasons. Conversely, the discovery, or imputation, of a woman's HIV-positive status can result in violence against her.

---


A. GBV Increasing Women's Risk of HIV Infection

1. Direct, Physiological Factors

The most common route of HIV transmission in Sub-Saharan Africa is through heterosexual sex. Physiologically, women appear to be at greater risk of contracting HIV than men due to increased biological susceptibility to sexually transmitted diseases (STDs) in general. The mucosal surface of the vagina is exposed to pathogens during sexual intercourse, making transmission of viruses like HIV more efficient in women. This is particularly so with younger girls whose genital tracts are not yet mature. In particular, forced sex with an HIV-infected partner is a key avenue of viral transmission. In such cases, the level of risk is influenced by the nature of intimate contact (vaginal, oral, anal), the degree of trauma, abrasion, or other tearing that occurs, and the presence of other sexually transmitted infections, which may render the uninfected partner less able to defend against the introduction of a new virus.

2. Indirect, Social Factors

Increasing attention has been paid to the non-biological factors exacerbating women's vulnerability to HIV infection. Among the numerous social factors rendering women susceptible is gender inequality and, specifically, violence against women.

Public health and medical studies conducted around the world have established correlations between social and structural gender inequality and women's rates of HIV infection. Repeated findings indicate that unequal gender relationships contribute to women's inability to protect themselves from HIV/AIDS and other sexually transmitted infections. Specifically, physical and sexual violence are


18. Id.

likely linked with HIV transmission for women in many contexts.\textsuperscript{20} The UNAIDS 2008 Report on the Global AIDS Epidemic noted that in several African countries like Tanzania, Rwanda, and South Africa, the risk of HIV among women who have experienced gender-based violence may be up to three times higher than among other women.\textsuperscript{21} This finding is borne out by other country-specific inquiries, such as a recent study in India, which found that married women experiencing physical and sexual violence from their husbands also exhibited an increased prevalence of HIV infection.\textsuperscript{22} Another study concluded that gender inequality among rural Ndau women in Zimbabwe was a factor obstructing HIV prevention.\textsuperscript{23}

Women's rights and advocacy groups representing People Living with HIV/AIDS (PLWHA) affirm this connection. The International Community of Women Living with HIV/AIDS (ICW) summarizes the key ways in which violence against women contributes to risk of HIV infection:

- Assaults, battery and the rape of children, especially girls, are frequent occurrences, and they perpetuate the spread of HIV directly (in the case of rape) and indirectly through promoting intra-familial fear that might prevent disclosure by a positive partner to a negative partner or prevent negotiation of safer sex;
- Social tolerance of violence against women prevents women from discussing the issue, leaving or confronting an abusive situation, or seeking help;
- Women may fear leaving an abusive relationship for fear of what will happen to the children if they have no child-custody rights;
- Myths and misconceptions and attitudes around HIV promote violence against women. For example, the belief that you can be cured by having sex with a virgin has led to

\begin{itemize}
\end{itemize}
a high incidence of rape of young girls. The coalition of women’s rights organizations known as Women Won’t Wait further notes that actual or threatened violence can keep women from negotiating safe sex or refusing sex when they normally would. Finally, the presence or threat of violence (physical, sexual, psychological) can make it difficult for women or girls to leave relationships that are violent, that are not monogamous, where partners won’t practice safer sex, or that they no longer want to be in for any other reason.

3. GBV Leading to Increased Risk of HIV Infection in Uganda

Though gender-based violence can be viewed from a macro or structural level (poverty, lack of education, lack of access to the legal system or representation, pervasive and harmful gender norms, etc.), certain discrete forms of harm against women have a direct relationship to risk of HIV infection. A brief survey of the major forms of harm reported by Ugandan women will set the stage for evaluation of legislative efforts to combat HIV and GBV alike.

a. Physical (Nonsexual) Violence Against Women

The 2006 Ugandan Demographic and Health Survey (UDHS) revealed that 59.6% of women in Uganda have experienced physical violence since age 15. There is indication that domestic/intimate partner violence accounts for much of this harm: among unmarried women, 52% reported having experienced physical violence in their lifetimes, whereas 62% of currently married and 63% of divorced/widowed/separated women reported the same. Moreover, 50.4% of Ugandan women reported physical violence committed by their current husbands/partners; 17.9% reported


violence from former husbands/partners.\textsuperscript{27}

Despite the great strides Ugandan women have made in terms of education, employment and civic participation, it seems that many are still constrained by deeply held social norms governing women’s subservient status in intimate relationships. The same 2006 demographic survey polled women’s views as to whether a husband would be justified in beating his wife under a series of circumstances: if the wife burns the food, argues with him, goes out without telling him, neglects the children, or refuses sexual relations. 70\% of women surveyed agreed that at least one of the reasons above would justify wife beating.\textsuperscript{28}

\textit{b. Sexual Violence/Rape}

The 2006 Uganda Demographic and Health Survey data show that 39\% of Ugandan women have experienced sexual violence in their lifetimes, compared to 11\% of Ugandan men. Like other forms of physical violence, sexual violence in Uganda often came at the hands of persons known to the victims, mainly women’s current partners (43.7\%).\textsuperscript{29}

It seems that the “ABC” prevention approach embraced by Ugandan policy makers (emphasizing abstinence, being faithful, and condoms) has its limitations, particularly among married women. Gruskin et al notes:

In Uganda, where ABC has been adopted and highly praised, married women, who are unable to practice abstinence, are still suffering from high rates of HIV infection. As mentioned earlier, culture frequently dictates that, in marriage, a woman often is not expected to give consent to sexual relations. It is estimated that up to 80\% of women throughout the world who were infected with HIV while in a long-term, stable relationship, were infected through their partners who had themselves become infected through sex outside their relationship or through drug use.\textsuperscript{30}

Human Rights Watch confirms that the majority of female clients seen by HIV/AIDS service providers in Uganda became

\begin{itemize}
\item \textsuperscript{27} Id. at 14-15.
\item \textsuperscript{28} 2006 UDHS REPORT, supra note 26, at 23. As will be discussed below, domestic violence was not explicitly outlawed in Uganda until November, 2009. Even now, marital rape lacks explicit criminalization.
\item \textsuperscript{29} See id. at 17.
\item \textsuperscript{30} Gruskin et al., supra note 2, at 89-90.
\end{itemize}
infected through unprotected heterosexual sex. Physicians providing care to Ugandan women note a high incidence of infection among wives who experience regular rape and battery at the hands of their husbands, who may be having extramarital relations. Despite knowledge of infidelity or desire to refuse sexual relations, many women passively continue in their relationships with their husbands. Women reported feeling that cultural norms dictated a marital obligation to provide their husbands with sex on demand.\textsuperscript{31}

c. Female Genital Mutilation

Female genital mutilation (FGM) refers to the range of procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. It has immediate and long-term health effects, including open sores, infection, and the formation of scar tissue around the vaginal area.\textsuperscript{32} The World Health Organization (WHO) estimates that FGM affects 100 million to 140 million women and girls worldwide. Africa's estimated share: 92 million women and girls over age ten.\textsuperscript{33}

However, the prevalence rate of FGM in Uganda is relatively low, as compared to many parts of Africa. FGM is only practiced by a few isolated ethnic groups in Kapchowra and in the Bukwo district, near Uganda's northeastern border with Kenya. According

---

33. Id. According to the World Health Organization, female genital mutilation is classified into four major types:

- Type I, Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
- Type II, Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).
- Type III, Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer labia, with or without removal of the clitoris.
- Type IV, Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g., pricking, piercing, incising, scraping and cauterizing the genital area.
to women’s rights advocates, 647 women between ages 11 and 31 in the eastern Kapchowra district were subjected to FGM in 2002. In 2004 and 2006, the numbers had decreased to 595 and 426, respectively. In the Bukwo district, 100 cases were reported in 2008.34

There are theories linking female genital mutilation to increased risk for HIV infection.35 Given that traditional cutters often use a single blade to cut several girls in a single group ritual, many women’s rights advocates are concerned that HIV can be transmitted if any one of the girls is already HIV-positive (as from mother-to-child transmission at birth). Though empiric data regarding this physiological connection is limited, it seems plausible that if the number of HIV-positive children in Uganda increases through untreated mother-to-child-transmission (MTCT), the number of HIV-infected girls in any particular group gathered for FGM will also increase. In addition, the formation of scar tissue due to FGM can increase the risk of tearing during intercourse or childbirth36 – creating increased opportunity for HIV transmission through blood.

d. Polygamy

Polygamy is still legal in Uganda. In 2000/2001, government statistics reported that 1 in 3 women in Uganda were married into

34. The low numbers in the early 2000s was likely due to increased outreach and awareness of FGM’s harmful consequences, as well as government incentives of livestock and other goods promised to traditional cutters who would lay down their blades. However, in 2008, the number of girls subjected to FGM rose sharply again – the traditional cutters reasoned that when the government did not fulfill its promises of alternate compensation, they were forced to resume FGM practice in order to generate income. See Uganda: Women petition court to outlaw FGM, IRIN, Apr. 30, 2007, http://www.irinnews.org/Report.aspx?ReportId=71867; see also Uganda: FGM Spreads in Bukwo, NEW VISION, Dec. 22, 2008, http://allafrica.com/stories/200812220412.html.

35. Klouman E. et al., Self-reported and observed female genital cutting in rural Tanzania: associated demographic factors, HIV and sexually transmitted infections, 10 TROPICAL MED. & IN’L HEALTH 1, 112 (2005) (citing Kun KE, Female Genital mutilation: the potential for increased risk of HIV infection, IN’L J. OF GYNECOLOGY & OBSTETRICS 59, 153-155 (1997)).

polygamous unions. Though it is debatable as to whether polygamy per se is a form of gender-based violence, women married in polygamy have certainly reported conflict with their husbands, and between co-wives, where the husband does not provide for his wives equally. Polygamy can complicate women's ability to retain or inherit marital property after the death of a husband, especially as many polygamous marriages are not civilly registered (or may include a mix of legal and unregistered marriages in one household). Further, in focus groups led by the Human Sciences Research Council, women in Iganga, Uganda indicated that they had difficulty trusting their co-wives with respect to exposure to HIV.

e. Customary Practice Regarding Widows

Though they are reportedly on the decline, certain practices concerning the treatment of widows exist in Uganda. One such practice, widow cleansing, is the custom by which a designated village "cleanser" or male relative of a deceased husband has sexual intercourse with a widow to "cleanse" her of her deceased husband's spirit, usually with no obligation to marry her. Because cleansing is often seen to be ineffective if a condom is used, women subjected to this practice have an increased risk of infection where the "cleanser" is HIV-positive. Presumably, where the widow herself is HIV-positive, she risks transmitting the virus to an uninfected "cleanser," who may in turn infect other partner(s).

A second custom that may place uninfected widows at risk for HIV is that of widow inheritance. Traditionally, this was a way to protect the widow and her children from economic hardship upon loss of a husband. The widow (and, often, her husband's land) would be "inherited" by a brother-in-law or other male relative of

39. Id.
41. UNPFA, supra note 36.
her deceased spouse, whereby she and her children would retain a place in the family and be permitted to continue living on the land. The practice of widow inheritance by the brother of the deceased has historically acted as a form of social protection that ensured that the needs of the mother and orphans were provided for by the clan. However, as the practice automatically transfers a widow and her property to a male relative, regardless of her consent, widow inheritance exposes women to new sexual partners and increases the likelihood of HIV and domestic violence.

Ironically, the decline of widow cleansing and widow inheritance has been attributed to fears of the HIV epidemic and growing fears that women widowed by AIDS are also infected. Relatives of deceased men have reportedly become reluctant to practice widow cleansing and inheritance for fear of infection. This can leave widows destitute, with nowhere else to turn.

B. Violence Against HIV-Positive Women

1. Being HIV-Positive Increases the Risk of Violence Against Women

Public health experts and community advocates observe that women in Sub-Saharan Africa are typically the first in their relationships to learn of their HIV status. This is generally attributed to the fact that women, on average, access health care earlier and more frequently than their male partners—particularly because they seek ante-natal care during pregnancy. Pregnant women are often tested for HIV in order to determine whether treatment is needed to ensure the mother's own health as well as avoid mother-to-child transmission of the virus. Regardless of

42. Swaminathan et al., supra note 38, at 122.
44. Swaminathan et al., supra note 38, at 122.
45. The World Health Organization estimates that 430,000 children became infected with HIV in 2008, over 90% of whom had contacted the virus during pregnancy or breastfeeding, through MTCT. Without therapeutic intervention, the risk of MTCT ranges from 20% - 45%. With interventions in non-breastfeeding women, the risk of transmission can be reduced to 2%. Among women who breastfeed, the risk can be reduced to 5%. See WHO, PMTCT STRATEGIC VISION 2010-2015: PREVENTING MOTHER-TO-CHILD TRANSMISSION OF HIV TO REACH THE UNGASS AND MILLENNIUM DEVELOPMENT GOALS 6 (2010), http://www.who.int/hiv/pub/
which partner in a relationship contracted HIV first, the woman is often made aware of her status earlier due to more frequent interactions with healthcare and testing. This discovery can result in her being blamed and punished by their partners for "bringing HIV into the relationship." Specifically, a woman discovered to be HIV-positive may face physical violence, stigmatization and social rejection, property violations on account of her HIV-positive status.

a. Physical Violence, Stigmatization and Social Rejection

Stigmatization of HIV/AIDS can result in a variety of challenges for an HIV-positive person in Uganda. A 2001 report by UNAIDS described forms of stigmatization and discrimination emanating from all levels of Ugandan society — from the micro-unit of family, to the broader realms of community, workplace, and religious institutions.

Within families, HIV-positive women reported being neglected by their parents-in-law, (particularly following the death of their son); wives also reported being neglected or thrown out by their husbands upon discovery of their HIV-positive status. There does not seem to be a corollary pattern of reprisal against husbands who are found to be HIV-positive. The few reports of women abandoning their HIV-positive husbands were explained by men in focus groups as likely stemming from women’s fear of reprisal and blame for the husband’s HIV infection.

Stigmatization within the family manifests itself in relation to inheritance, especially in cases where an HIV-positive husband has died and his widow is evicted from the matrimonial home by her in-laws. Even apart from cases in which a husband dies, HIV-positive women often lose the support of family members, or are passed over by relatives bequeathing property.

It is not only women who suffer this discrimination from family members. HIV-positive men are also passed over by relatives distributing property. Lending money or bestowing gifts upon someone who is "going to die because they have ‘slim’" is seen to be

46. Interview with ICW advocates, in Kampala, Uganda (Aug. 2008).
48. Id. at 13-14.
a wasted investment.\textsuperscript{49}

The 2001 UNAIDS report on discrimination and stigmatization of HIV/AIDS in Uganda found that at the community level, a person’s HIV-status was frequently a source of gossip and isolation.\textsuperscript{50} Employers were known to require HIV-testing before offering an applicant a job, or before investing in a worker’s training.\textsuperscript{51} Stigmatization was also reported in the realms of religious institutions, where HIV was linked by priests and imams alike with sinful promiscuity and so infected persons often felt judged by, and isolated from, their faith communities.\textsuperscript{52}

Though the 2001 UNAIDS report may be slightly dated in light of growing understanding of HIV/AIDS in Uganda, PLWHA advocates in Uganda confirm that a woman who is discovered to be HIV-positive can still be seen to have brought HIV into the home. For this, she can be subjected to violence by her spouse, family, in-laws, and other members of her community. Stigmatization for being HIV-positive can result in rejection, discrimination, isolation, and loss of support when it is needed most. This stigma can be internalized to the point that an already subjugated woman may suffer such shame and lack of confidence that she is unable to leave a violent relationship or confront the perpetrator of violence.\textsuperscript{53}

\textit{b. Property Grabbing}

There is an old Ugandan saying about women’s rights to ownership of land: “[p]roperty can’t own property.”\textsuperscript{54} This view has been reflected in Uganda’s intestacy and inheritance laws for over a century. For example, the inheritance laws on the books since 1906 defined “legal heir” as “the living relative nearest in degree to a intestate...” with an additional qualification: “a male shall be preferred to a female.”\textsuperscript{55} Although Ugandan women can formally own property and inherit property through an explicit will or intestate succession, women still encounter difficulty in securing

\begin{itemize}
\item \textsuperscript{49} Id. at 14-15.
\item \textsuperscript{50} Id. at 15-16.
\item \textsuperscript{51} Id. at 19.
\item \textsuperscript{52} Id. at 20.
\item \textsuperscript{53} Id.
\item \textsuperscript{55} Succession Act of 1906 ch. 162, § 2(n)(ii).
\end{itemize}
their property rights.\textsuperscript{56} Women in Uganda generally do not enjoy ownership rights to the land on which they live. Instead, they frequently possess no more than “user” rights (as in cultivating it for crop production). By statute, widows are also permitted to stay in the matrimonial home until they remarry or die. However, in many cases, Ugandan women are unable to exercise these formal rights because of poverty, unfamiliarity with the law, general lack of access to the justice system, and the force of customary law.\textsuperscript{57}

Where a woman has been blamed for “bringing HIV” into the home, she may be cast out of the matrimonial home and be forced to either return to her parents’ home or fall into utter destitution. Human Rights Watch found that women in Uganda were often more afraid of eviction from the family home than they were of physical violence at their husband’s hands. One woman interviewed described being the third of three wives, whose co-wife had already died of AIDS. She had been too afraid to access HIV/AIDS information because she feared her husband would evict her:

I wouldn’t dare because if I was HIV-positive he would say I brought the virus into the home.... I have seen very many women being chased away by their husbands. Many have been chased and beaten. I was scared of being thrown out. Beating, someone can beat you and he forgives you. I was scared of being thrown out.\textsuperscript{58}

Widows are particularly vulnerable to eviction by in-laws after the death of their husbands. A study comprised of 29 Ugandan widows living with HIV reported that 90% had property wrangles

\textsuperscript{56} The gender-discriminatory provisions in the 1906 intestate succession and inheritance law were struck down as unconstitutional in 2006 by Uganda’s Constitutional Court in a case launched by Law and Advocacy for Women in Uganda (LAW-U). However, the Parliament has not affirmatively enacted remedial legislation to fill the gaps left in the law once the discriminatory clauses were stricken. Certain provisions protecting women’s rights to marital property and inheritance were included in a proposed family law (formerly known as the “Domestic Relations Bill”) — however the current incarnation of the bill has stalled in Parliament. At this time, the void in legislation persists, creating a lack of statutory property rights for women in Uganda. \textit{See Law & Advocacy For Women in Uganda v. Attorney Gen. of Uganda, Constitutional Petition Nos. 13/05 & 05/06, in possession of author.}


\textsuperscript{58} \textit{JUST DIE QUIETLY}, supra note 31, at 38.
with in-laws. Additionally, 88% of those in rural areas were unable to meet their household needs. Where a woman’s husband has died from HIV/AIDS, the woman is frequently also infected — and can be blamed by her in-laws for the death of her spouse. “Property grabbing” is a customary practice by which, upon the death of a clansman, his widow is disenfranchised from ownership of the matrimonial home left to her by her spouse, including property that the wife owned herself or that she acquired jointly with her husband. In-laws who subject widows to property grabbing often justify this violent practice by blaming widows for bringing about their husbands’ deaths. Additionally, “suspicion about HIV and AIDS tended to cause the husband’s parents to react negatively towards the daughter-in-law and her children.”

2. Fear of Violence Negatively Impacts Women’s Ability to Access Health Care

Fear of violence from a husband or intimate partner was reported to be a major barrier to disclosure of HIV status among 16%-51% of HIV-positive women surveyed in Tanzania, South Africa, and Kenya.

Gender violence can also negatively affect an HIV-positive woman’s ability or willingness to access treatment. Women in an Alabama clinic reported an inability to pursue regular care because their abusers had: inflicted recent, embarrassing bruises; prohibited them from attending the clinic lest they be seen; taken their travel money; evicted them; or otherwise isolated and immobilized them. Fear of violence, retaliation, or abandonment frequently prevented the HIV-positive women from disclosing their health status to their partners.

Similar obstacles to accessing care were found among Ugandan


61. Monico et al., supra note 47, at 28.

62. CRITICAL INTERSECTIONS, supra note 19, at 4.

women's experiences in a study, which indicated that women feared asking their partners for money or permission to attend HIV/AIDS treatment centers. In some cases, they were explicitly forbidden by their husbands from taking HIV tests. A 2006 study in Uganda found that women fearing intimate partner violence were reluctant to test for HIV, disclose positive results, and request condom use. Further, women who are disempowered in their relationships may fear disclosing positive test results due to the threat of violence or abandonment. Fear of status-discovery may also prevent a pregnant, HIV-positive woman from using safer infant feeding options once the baby is born — she may nurse her child regardless of risk of transmission through breast milk, in order to avoid suspicion of being HIV positive.

III. Uganda's Obligations to Protect Women's Rights

As a threshold matter, Uganda has undertaken to protect women's rights through both domestic and international law. First, the Constitution of Uganda is a progressive document, explicitly granting women's rights by providing them "full and equal dignity of the person with men." It also provides, "[a]ll persons are equal before and under the law in all spheres of political, economic, social and cultural life and in every other respect and shall enjoy equal protection of the law.... [A] person shall not be discriminated against on the ground of sex, race, colour, ethnic origin, tribe, birth, creed or religion, social or economic standing, political opinion or disability." The Constitution also anticipates tension between statutory and customary law in Uganda, providing that "[l]aws, cultures, customs or traditions which are against the dignity or interest of women or which undermine their status, are prohibited by this Constitution."

Beyond the Constitution, Uganda has undertaken to meet

64. JUST DIE QUIETLY, supra note 31.
65. Karamagi et al., supra note 37.
67. UGANDA CONST. (Constitution Act 1995) art. 33(1).
68. UGANDA CONST. art. 21.
69. UGANDA CONST. art. 33(6).
obligations imposed by international (and regional) human rights instruments.

Uganda signed the International Covenant on Civil and Political Rights (ICCPR) in 1995. Many of the rights reflected in the ICCPR are relevant to the issue of HIV/AIDS, including the right to marry and found a family (Article 23), the right to privacy (Article 17), freedom of expression and information (Article 19), freedom of assembly and association (Article 22), freedom of movement (Article 12), the right to liberty and security of person (Article 9), and freedom from cruel, inhuman or degrading treatment or punishment (Article 7). Further, in 1987, Uganda acceded to the International Covenant on Economic, Social, and Cultural Rights — Article 12 of which articulates the right to the highest attainable standard of physical and mental health.

Additionally, Uganda signed the Convention on the Elimination of Discrimination Against Women on July 30, 1980, ratifying it on July 22, 1985. Uganda has since filed three reports (most recently in 2000). CEDAW requires that state parties not only refrain from discriminating against women but also affirmatively provide protection against discrimination. Among Uganda's affirmative obligations under CEDAW is its duty to “take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise.” Uganda is also obligated to “take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women.”

As a member of the African Union, Uganda has signed, but not ratified, the Protocol to the African Charter and Human Peoples'
Rights on the Rights of Women in Africa.\textsuperscript{78} This is particularly unfortunate with regard to the plight of women faced with HIV, as the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa is the only international treaty to specifically address women's rights in relation to HIV/AIDS.\textsuperscript{79} In particular, the protocol provides women with "the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS."\textsuperscript{80} It also provides "the right to be informed of one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices."\textsuperscript{81}

Finally, as a member of the Great Lakes Region, Uganda is party to the Pact of Security, Stability and Development in the Great Lakes Region. Article 11 consists of the Protocol on the Prevention and Suppression of Sexual Violence Against Women and Children.\textsuperscript{82} Unlike the African Union protocol, Uganda recently ratified the Great Lakes Region Protocol.\textsuperscript{83} In doing so, Uganda undertook to "combat sexual violence against women and children through

\begin{footnotesize}
\begin{enumerate}
\item \textit{Id.} at art. 14(1)(e).
\end{enumerate}
\end{footnotesize}
preventing, criminalizing and punishing acts of sexual violence, both in times of peace and in times of war, in accordance with national laws and international criminal law.”

The protocol’s definition of sexual violence explicitly includes the “infection of women and children with sexually transmitted diseases, including HIV/AIDS.”

IV. Legislating HIV Prevention

A. International Guidelines on HIV/AIDS and Human Rights

After years of international consultation, the Office of the UN High Commissioner for Human Rights and UNAIDS issued the International Guidelines on HIV/AIDS and Human Rights (International Guidelines) in 1998 to provide human rights-oriented guidance for States’ efforts to combat the HIV/AIDS epidemic. Periodic international consultations have resulted in revisions and updates to the guidelines — a consolidation of which was published in August, 2006. The stated purpose of the consolidated guidelines is “to assist States in translating international human rights norms into practical observance in the context of HIV.” Specifically, the International Guidelines highlight and elucidate UN member states’ obligations according to international human rights instruments such as the United Nations Charter, the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, and the International Covenant on Civil and Political Rights.

There are currently twelve individual guidelines. They represent the practical, human rights-informed standards by which any proposed HIV/AIDS prevention and control laws should be measured.

84. Pact on Security, Stability and Development, supra note 82, at art. 11
86. CONSOLIDATED INT’L GUIDELINES, supra note 14, at 13.
B. Brief Overview of HIV Legislation in Africa

In Africa, legislative efforts concerning HIV prevention are well-underway. HIV control laws currently exist in about a dozen West African countries, including Guinea, Guinea-Bissau, Mali, Niger, Togo, Gambia, Cote d'Ivoire, Benin, and Sierra Leone. In Guinea, Guinea-Bissau, Mali, and Niger, a woman can be criminally liable for failing to take steps necessary to prevent HIV transmission to her unborn baby. Guinea also requires mandatory HIV testing for couples planning to marry. Togolese legislation requires periodic mandatory HIV and STD testing of sex workers. In Togo, HIV-positive people are also prohibited from having unprotected sex, regardless of whether they have disclosed HIV-positive status to their partner.

South African countries have been slower than East or West Africa to criminalize HIV transmission despite the region's dramatically high rate of infection. South Africa and Botswana have simply modified existing criminal code provisions to include enhanced sentencing for rape committed by an HIV-positive person. As of December 2008, Malawi's legislature was considering a bill that would criminalize HIV transmission.

The East African Community is drafting a regional HIV law, as requested by the East African Legislative Assembly, which would cover five member states: Kenya, Uganda, Tanzania, Burundi, and Rwanda. (Kenya, Tanzania, and Burundi already have HIV/AIDS laws.) Consultations reveal that proposed law would criminalize

88. Most of these laws were based on “African Model Law” — drafted in September, 2004, in N'Djamena, Chad. It provided, inter alia, that HIV-positive person must disclose their status to sexual partner(s) as soon as possible (6 weeks maximum) — or physicians can notify the patient’s spouse or partner. The draft law also provided for mandatory HIV testing for pregnant women, and in cases of marital dispute. A keen critique of the N'Djama document was issued by UNAIDS. See JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS, UNAIDS RECOMMENDATIONS FOR ALTERNATIVE LANGUAGE TO SOME PROBLEMATIC ARTICLES IN THE N'DJAMENA LEGISLATION ON HIV (2004), available at http://data.unaids.org/pub/Manual/2008/20080912_alternativelanguage_ndajema_legislation_en.pdf.


HIV transmission. Penal codes in Kenya, Rwanda, Burundi, and Tanzania preclude prostitutes and homosexual men from access to HIV treatment. 92

V. Uganda’s HIV and AIDS Prevention and Control Bill (2009)

Introduced in the fall of 2008, Uganda’s HIV and AIDS Prevention and Control Bill underwent a first round of consideration by the Committee on HIV/AIDS and Related Matters. After an initial round of revision based on feedback from advocacy organizations, the proposal remains under consideration as of Spring, 2010. The version available as of August, 2009, contains many positive measures, including the provision of pre- and post-test counseling, in accordance with UNAIDS International Guidelines.93 It also provides for the provision of anti-retroviral treatment to any HIV-positive people who need it.94 Further, the bill requires that all health-care providers be licensed and regulated to ensure quality of care.95 Finally, discrimination against HIV-positive people is prohibited in various settings — employment, insurance, housing, etc.96

However, certain provisions of the bill conflict with international norms and guidelines, as well. In light of the prevalence of gender-based violence suffered by many women in Uganda, many of these provisions pose an unintended threat to their welfare. Specifically, the bill’s current provisions concerning a) mandatory testing, b) exceptions to confidentiality, c) overbroad disclosure permissions, and d) criminalization of intentional transmission may negatively impact both women’s human rights and their health outcomes.97


94. Id. at pt. IV, cl. 27.

95. Id. at pt. III, cl. 26.

96. Id. at pt. IV.

97. The bill also contains conduct requirements that are unrealistic in the
A. HIV Testing and Counseling

The right to privacy (as in matters of health status) is reflected in Article 17(1) of the ICCPR. Further, the Committee on Economic, Social, and Cultural Rights has also recognized the right to the highest attainable standard of health and the importance of respecting medical ethics and confidentiality by health facilities and programs.88

For twenty five years, WHO and UNAIDS have urged that HIV testing be performed only upon condition of the "3-C's"—namely, a) confidentiality (of testing and results), b) consent (to be tested upon full information), and c) counseling (pre- and post-testing.)99

The World Bank, in its report, "Legal Aspects of HIV/AIDS: A Guide for Policy and Law Reform" emphasizes the need for informed consent in any case of routine offers of HIV testing—either through requiring an affirmative indication of willingness to be tested ("opt-in" consent) or providing for testing by default though only with a patient possessing the clear ability to "opt-out."100

1. International Guidelines Regarding Testing and Counseling

The consolidated 2006 International Guidelines on HIV/AIDS and Human Rights reflects the "3-C's" approach. They offer clear criteria for who should be tested, and how. Specifically,

• Guideline 3(20)(b): public health legislation should ensure that HIV testing of individuals should only be performed with the specific informed consent of that individual.

context of gender inequality in many sexual relationships. Clause 3(2) addresses prevention: "A person shall use protective measures to protect him or herself and others from infection with HIV during sexual intercourse." Where at first this provision speaks common sense and precaution, it is problematic in light of certain gendered realities many women face. Women's rights advocates in Uganda remind that it can be difficult for women to insist on use of protective measures such as condoms where there is a power imbalance between partners. This is particularly the case for the most vulnerable among them — women in abusive relationships, or women forced into sex due to economic necessity. Id. at pt. II, cl. 3(2).


100. LEGAL ASPECTS OF HIV/AIDS, supra note 87, at 3-4.
• Guideline 3(20)(c): public health legislation should ensure, whenever possible, that pre- and post-test counseling be provided in all cases.

• Guideline 3(20)(e): data protection and confidentiality should be ensured when HIV/AIDS cases are reported to public health authorities for epidemiological purposes.

• Guideline 3(20)(j): recommends that public health legislation require that health-care workers be trained, licensed, and held to standards of human rights and ethics (including HIV-related issues such as confidentiality and the duty to provide treatment).  

Mandatory HIV testing is testing without consent. As such, it conflicts not just with the "3-C's” approach and international HIV prevention guidelines, but with foundational human rights such as "liberty and security of the person.” It has also been vigorously opposed by the World Health Organization and the Joint United Nations Programme on HIV/AIDS.

2. The HIV Bill Regarding Testing and Counseling

Several provisions contained in the current draft of Uganda's HIV and AIDS Prevention and Control Bill (2009) contravene international guidelines regarding HIV testing and counseling. For example, Part II of the bill provides:

Consent to HIV test may be dispensed with where (a) it is unreasonably withheld, or (b) 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 following persons shall be subjected to HIV test for purposes of criminal investigation where —

a) a person is convicted of a drug abuse or possession of hypodermic instrument associated with drug abuse;

b) a person is charged with a sexual offence;

c) a person is convicted of an offence involving prostitution.

---

102. ICCPR, supra note 70, art. 9.
103. UNAIDS/WHO POLICY STATEMENT ON HIV/AIDS TESTING, supra note 99.
104. HIV Bill, supra note 93, at pt. II, cl.12.
105. Id. at pt. II, 13 (emphasis added).
The following persons shall be subjected to routine HIV test for purposes of prevention of HIV transmission — a) the victim of a sexual offence; b) a pregnant woman; c) a partner of a pregnant woman.106

3. Impact on Women in Uganda

The above provisions may harm women.107 As a baseline matter, Clauses 12, 13, and 14 run contrary to international guidance regarding the importance of obtaining informed consent before proceeding with any HIV testing. Clauses 13 and 14 effectively provide for mandatory (consentless) testing of certain groups (from sex offence suspects to pregnant women), contravening international standards.

Clause 13’s provision for testing in the context of criminal prosecution has been criticized by Human Rights Watch: "[m]andatory testing of criminal suspects has no appropriate forensic purpose."108 In its comments on the Ugandan HIV Bill, Human Rights Watch posited that such a practice does not necessarily protect the health of the victim of a sexual offence to have the suspect tested for HIV — if the alleged rapist had been recently infected, he may not yet have produced HIV antibodies that would trigger a positive result in either his or his victim’s testing. Reliance on false negatives may lead a victim of sexual assault to assume she is HIV-negative and to not undergo follow-up testing. (To this point, medical experts indicate that recent advances in testing technology have actually minimized much of the earlier uncertainty of “window period” test results such that this is no longer a significant concern.)109

Clause 14’s focus on the mandatory testing of pregnant women and their partners poses a more persistent set of concerns. As

106. Id. at pt. II, cl. 14 (emphasis added).
107. Part II of the HIV Bill includes Clause 20, which provides for the confidentiality of test results and counseling information and makes breach of confidentiality a civil offense, HIV Bill, pt. II, cl.20. See also, id. pt. II cl.21 & pt. III (asserting in Clause 21 that there are certain exceptions to confidentiality, which related to disclosure of HIV test results, the subject of Part III of the HIV Bill.).
109. Interview with Dr. David Bangsberg, Harvard Medical School (Mar. 2010).
A Paradox of Protection?

mentioned earlier, it is generally observed that women in Africa present themselves to healthcare providers more frequently than men, particularly due to the need for antenatal care during pregnancy. It is at this juncture that they are offered HIV testing in order to determine whether treatment to avoid “vertical transmission” of the virus from mother to child is necessary. In 2007, only 600,000 pregnant women of 1.4 million were tested for HIV — 91,000 were found to be HIV-positive. The Bill’s provision for mandatory testing of pregnant women (Cl. 14 (b)) threatens to rob the most vulnerable women of their right to make informed decisions about their health care. Clearly, it is preferable for any risk of vertical transmission to be detected and prevented. However, despite the desire to protect their unborn children from HIV infection, there are likely many reasons some pregnant women are hesitant about HIV testing — one principal reason being fear of identification as (and being ostracized or punished for) being HIV-positive. As Human Rights Watch noted in both its comments on the HIV Prevention and Control Bill (2009) and its findings about domestic violence and women’s HIV risk in Uganda, “[m]andatory testing ... potentially exposes women to the risk of intimate partner violence and abandonment by male partners, especially when disclosure to sexual partners is mandatory.”

Further, Clause 12(a) affords overly broad permission of a medical care provider to proceed with testing without consent where consent is “unreasonably withheld.” It is unclear what the standards for “reasonable withholding” are, or which parties are qualified to make the determination in any given case. It is certainly imaginable that a woman fearing reprisal for a positive test result may have difficulty explaining her inability to consent to her healthcare providers. In such a case, withholding of consent may be deemed “unreasonable” without full appreciation of the woman’s circumstances. Or, worse yet, a woman who does manage to articulate a fear of harm if results are positive might nonetheless be deemed to be unreasonably withholding consent.

Finally, it is unclear how practicable the requirement of Article 14(c) would be. Mandatory testing of every partner of every woman


111. HRW Comments, supra note 108, at 3. See also JUST DIE QUIETLY, supra note 31.
who becomes pregnant (and who presents herself for healthcare during the pregnancy) would amount to nearly universal HIV testing among Uganda’s heterosexual adult population. If this is in fact the legislators’ intent, education and counseling to couples before women become pregnant would be a more fruitful route to detection and prevention.

B. Notification and Disclosure

Disclosure of HIV-positive status on one’s partner(s) has been encouraged by public health experts as a way to promote both the disclosing partner’s ability to access treatment openly, as well as to bring about testing of his/her partner, who may need HIV treatment as well. For example, women who disclose their HIV-positive status to their partners may be more able to engage in programs to prevent MTCT when pregnant and nursing. Studies also indicate that individuals who disclose their HIV-positive status have better adherence to HIV medical treatment regimens. Disclosure also enables a partner to seek testing him or herself and to take any necessary steps toward avoiding infection (if negative) or seeking care (if positive).

1. International Guidelines regarding Notification and Disclosure

Disclosure to sexual partners should ideally be left to the HIV-positive party, or enabled by healthcare providers with the HIV-positive party’s consent. However, international guidelines anticipate certain limited circumstances under which a medical practitioner can effect disclosure of a patient’s health status without that patient’s consent. The Consolidated International Guidelines on HIV/AIDS and Human Rights addresses public health legislation in Guideline 3(20)(g). It states that disclosure of HIV results to third party by health-care professionals may be authorized, but only in accordance with the following conditions:

- The HIV-positive person in question has been thoroughly counseled;
- Counseling of the HIV-positive person has failed to achieve appropriate behavioral changes;

• The HIV-positive person has refused to notify, or consent to the notification of his/her partner(s);
• A real risk of HIV transmission to the partner(s) exists;
• The HIV-positive person is given advance notice;
• The identity of the HIV-positive person is concealed from the partner(s), if this is possible in practice; and
• Follow-up is provided to ensure support to those involved, as necessary.

2. The HIV Bill Regarding Notification and Disclosure

Part III of the Ugandan HIV and AIDS Prevention and Control Bill (2009) addresses disclosure in Clauses 22 and 23. Specifically, it provides:

Medical provider intending to disclose the HIV test results to a third party shall inform the tested individual of a.) the nature and purpose of disclosure; b.) date of disclosure, and c.) the recipient of the information.113

A Medical practitioner or other qualified officer who carries out an HIV test may notify the sexual partner of the person tested where he or she reasonably believes that the HIV positive person poses a risk of HIV transmission to the partner and the person has been given reasonable opportunity to inform their partner(s) of their HIV positive status and has failed to do so.114

Subject to subsection (1) before notifying the partner of the HIV positive person a medical practitioner or other qualified officer shall: - a.) counsel the HIV positive person and his or her partner; b.) inform the person in advance of the intended notification, c.) ensure that follow-up is provided to ensure support to those involved as necessary.115

It should be noted that Clause 21 (which actually appears in Part II of the HIV Bill, regarding Testing and Counseling) asserts certain exceptions to confidentiality regarding test results, as where “any other person with whom an HIV infected person is in close or continuous contact including but not limited to a sexual partner, if the nature of contact, in the opinion of the medical (sic) practitioner, poses a clear and present danger of HIV transmission to that

113. HIV Bill, supra note 93, at pt. III, cl. 22.
114. Id. at cl. 23(1).
115. Id. at cl. 23(2).
person.”116

3. Impact on Women in Uganda

The provisions of the HIV Bill concerning confidentiality and disclosure pose a few challenges. First, Clause 21 lies in tension with Clause 23, insofar as it waives confidentiality of HIV results where the medical practitioner has identified anyone (sexual partner or otherwise) who is in “clear and present danger” of contracting HIV from the tested individual. This differs significantly from the provisions of Clause 23, which permit the consentless disclosure of HIV test results to any sexual partner who runs “a risk of HIV transmission” from the tested person.

Second, the Part III provisions do not meet the standards for confidentiality and disclosure established by the International Guidelines. The bill permits a health-care provider to notify a patient’s sexual partner simply where he/she “reasonably believes” there is risk of HIV transmission to the partner (as opposed to the “real risk of transmission” language in International Guideline 3), and where the patient has failed to notify the partner him or herself despite “reasonable opportunity.” It is unclear how “reasonableness” should be measured. International Guideline 3 also requires health-care providers to consider whether the HIV-positive person has at all modified behavior or position regarding disclosure after counseling – even gradually – and whether he/she has outright refused to disclose to his/her partner. These guidelines appreciate the fact that readiness to disclose HIV status is rarely immediate, nor does the situation or delay in disclosing amount to outright refusal. The Ugandan bill does not mention these intermediate stages in assessing when independent disclosure by the medical practitioner is appropriate. If Clauses 21 and 23 are to stand, they should be enhanced to include clarified steps for assessing a tested individual’s good faith efforts to move towards disclosure, as well as care to conceal the HIV-positive person’s identity when practicable.

It is also unclear how a medical provider will determine whether a patient has in fact informed his/her partner(s) without blatantly violating the consent and confidentiality provisions asserted elsewhere in the bill. Finally, the bill does not require

116. Id. at cl. 21 (f).
health-care providers to avoid revealing the HIV-positive person’s identity wherever possible, as advised by International Guideline 3.\textsuperscript{117}

The Ugandan bill’s disclosure provisions are gender-neutral, and should in theory protect both men and women who are placed on notice that their sexual partners are HIV-positive. However, given the realities of who is typically tested earlier, as well as the power differential between genders in many intimate relationships, the provision risks having a negative impact on women.

First, as noted earlier, women are believed to learn of their HIV-status earlier than men because they present to clinics for antenatal care when they are pregnant. They are often tested for HIV in order to protect their health, and their babies’ health, during the course of pregnancy and after childbirth. Men often do not seek medical care as early — they are often only tested for HIV at much later stages, after they have already begun to feel unwell or exhibit symptoms.\textsuperscript{118} Thus, with the often disparate “discovery” times, knowledge of HIV-positive status requiring disclosure falls more frequently to women.

Second, the impact of forced disclosure can also be different for men and women. Where the infected partner occupies a disempowered position in a relationship, there can be very real consequences of rejection or reprisal for having “brought HIV into the house.”\textsuperscript{119} Given the relative rates of domestic violence by gender in Uganda, it is clear that women are more likely to face negative consequences from their partners as a result of disclosing HIV-positive status.\textsuperscript{120} Human Rights Watch, in its substantial findings on domestic violence and HIV among women in Uganda, found that many women explained “how they were afraid to discuss HIV/AIDS with husbands who were clearly unwell, how a fear of violence prevented them from openly attending HIV/AIDS sensitization programs, and how, despite feeling unwell themselves,
they were unable to go for HIV testing or were too scared to pick up the results." The burden of actually having a positive diagnosis to share, then, must be much more difficult. One woman Human Rights Watch interviewed who had never revealed her HIV-positive status to her husband described her inability to disclose as follows:

I am married but I came alone [for testing]. I never informed him. He said, "if I know you're positive I'm going to kill you." We used to quarrel. He beat me. I never talked about it.... I get scared that [the children] will tell him they were injected. I can't even test the children because he'll be angry and ask why.

It is quite true that a partner's response can be extreme. In 2008, Dr. David Apuuli Kihumuro, head of the Uganda AIDS Commission, reported that at least three women had been killed by their husbands that year when they were discovered to be HIV-positive. There are no parallel reports of male partners being killed, or even beaten, by their female partners after having disclosed their HIV-positive status. In short, though disclosure is critical from a public health perspective and though it benefits both infected and non-infected parties, some individuals will resist disclosing their status. Medical practitioners should explore the gravity or likelihood of real danger to the HIV-positive person before taking it upon him or herself to disclose without the person's consent. Failure to do so may put the most vulnerable populations — including those with legitimate fears of abuse — at risk. The HIV Bill does not require full consideration of these factors by the medical practitioner.

C. Criminalization of 'Intentional' HIV Transmission

There are no data indicating that the broad application of criminal law to HIV transmission will achieve either criminal justice or prevent HIV transmission. Rather, such application risks undermining public health and human rights.

The UNAIDS Reference Group on HIV and Human Rights emphasizes that any criminalization of HIV transmission must be

121. See JUST DIE QUIETLY, supra note 31, at 28.
122. See id.
123. UGANDA: Draft HIV Bill's Good Intentions Could Backfire, supra note 110.
limited to cases of intentional and actual transmission. Instead of enacting specific HIV-criminalization legislation, it recommends legislative and policy support of prevention and treatment strategies.\textsuperscript{125}

1. International Guidelines Regarding Criminalization

Specifically, International Guideline 4 ("Criminal Laws and Correctional Systems") urges states to "review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV or targeted at vulnerable groups." Guideline 4, clause 21(a) continues: "[c]riminal and/or public health legislation should not include specific offences against the deliberate and intentional transmission of HIV but rather should apply general criminal offences to these exceptional cases. Such application should ensure that the elements of foreseeability, intent, causality and consent are clearly and legally established to support a guilty verdict and/or harsher penalties."\textsuperscript{126}

2. The HIV Bill Regarding Criminalization

Part IV of the Ugandan bill criminalizes HIV transmission and asserts exceptions to criminal liability as follows:

- A person who attempts to transmit HIV to another person commits a felony.\textsuperscript{127}

- Any person who willfully and intentionally transmits HIV to another person commits an offence, and upon conviction shall be liable to life imprisonment.\textsuperscript{128}

- A person shall not be convicted of an offence under subsection (1) if — (a) the other person was aware of the HIV status of the accused and the risk of infection and he or she voluntarily accepted the risk; (b) the alleged transmission was through sexual intercourse and protective measures


\textsuperscript{126} \textit{CONSOLIDATED INT’L GUIDELINES, supra} note 14, at 29.

\textsuperscript{127} HIV Bill, \textit{supra} note 93, at pt. IV, cl. 39(1).

\textsuperscript{128} \textit{Id.} at pt. IV, cl. 41(1).
were used during penetration.\textsuperscript{129}

- The provisions in this Part shall not apply to any transmission of HIV by a mother to her child before or during the birth of the child.\textsuperscript{130}

3. Impact on Women in Uganda

Clause 39(1) is dangerously vague— in criminalizing “attempted” transmission of HIV, it does not define what constitutes an attempt, nor does it require proof of \textit{mens rea} (bad intent). It also conflicts with the principle outlined by the UNAIDS Reference Group on HIV and Human Rights that only intended and \textit{actual} transmission of HIV constitute grounds for prosecution. Further, though willful and intentional transmission of HIV may arguably justify application of criminal penalties, legislation should explicitly delineate how the accused's \textit{intention} should be determined. Article 41 does not sufficiently provide for this necessary inquiry.

With respect to the potential effect of criminalization of HIV transmission on women, the UNAIDS Reference Group on HIV and Human Rights states,

... the highest priority should be given to laws protecting women’s full enjoyment of all human rights and their right to be free from violence. This recognizes that applying criminal law to HIV transmission does nothing to prevent the spread of HIV or to address the economic, social, and political marginalization that are at the root of gender-based violence and women's vulnerability to HIV. On the contrary, for the reasons outlined in the UNAIDS/UNDP policy brief, including the fact that women are often the first to learn their status within a couple, these laws are likely to be used to prosecute women more often than men. Criminalization of HIV transmission and exposure also will not protect women from coercive or violent behavior such as rape, that can transmit HIV. Indeed, many countries that already have strong anti-rape laws fail to enforce them. Instead of additional, ineffective HIV-specific laws that will be used against them, urgent efforts are need (sic) to ensure timely, effective, and aggressive prosecutions of all forms of gender-based violence, and to ensure that victims of sexual violence receive post-exposure

\textsuperscript{129} \textit{Id.} at pt. IV, cl. 41(2).
\textsuperscript{130} \textit{Id.} at pt. IV, cl. 46.
prophylaxis that will reduce their risk of contracting HIV.\textsuperscript{131}

Representatives of the National Forum of People Living with HIV/AIDS Networks in Uganda agree that criminalization of HIV transmission will immediately affect women's willingness to disclose HIV-positive status, and consequently lead to an increase in cases of "silent" transmission in Uganda.\textsuperscript{132}

Human Rights Watch notes another problem in Clause 46, which may negatively impact women. The provision exempts mothers who transmit HIV to their child before or during childbirth. It does not account for the likelihood of HIV transmission through breastfeeding once the infant of an HIV-positive woman is born. Failure to account for cases of mother-to-child transmission of HIV after childbirth creates the possibility of criminal prosecution of mothers who may unwittingly infect the infants they nurse. In its comments, Human Rights Watch recommends that, "[i]f there is any reference to criminalization in the final bill, exemption needs also to include the time period after birth."\textsuperscript{133}

If the omission of exemption for post-birth transmission by a mother is \textit{intentional} on the part of Ugandan legislators (to penalize HIV-positive women who breastfeed their children), it is of even more concern. First, an HIV-positive woman who is unaware of her infection status could be prosecuted for \textit{unwittingly} transmitting the HIV to the child she breastfeeds. Second, prosecution of women who \textit{know} they are HIV-positive and yet breastfeed their infants may punish the most vulnerable mothers — those who have no access to information about the risks of HIV transmission through breastmilk, and those who may have reason to fear violence if suspected of being HIV-positive (due to use of formula instead of breastfeeding).

\section{VI. Does Uganda \textit{Need} HIV Control Legislation?}

For years, the Ugandan government has effected a relatively successful HIV control program not through legislation, but through

\begin{footnote}{131. Statement on Criminalization, \textit{supra} note 125.}
\end{footnote}

\end{footnote}

\begin{footnote}{133. HRW Comments, \textit{supra} note 108, at 8.}
\end{footnote}
public health policies and programs. Programs include the National HIV and AIDS Strategic Plan (NSP) (2007/8 – 2011/2012), the National Policy Guidelines for Voluntary HIV Counseling and Testing (VCT)(2003) and National Policy Guidelines for HIV Counseling and Testing (HCT)(2005), and the National Policy on HIV/AIDS and the World of Work. Opponents of the HIV Bill argue that it is pointless, saying that many of the beneficial provisions of access to HIV treatment, enjoyment of confidentiality, and freedom from discrimination on account of health status are already available through policy and other legislation. Others say it is helpful to consolidate gains and progress in the form of legislation, but that the HIV Bill is not, in fact, necessary.

In light of the aforementioned concerns, it is unclear that pursuit of the HIV and AIDS Prevention and Control Bill (2009) as written is helpful, much less the best next step. The services and protections it offers are largely provided for in existing government policies and programs, while the testing, disclosure, and criminalization provisions undermine several of Uganda’s obligations under international human rights law.

The HIV bill’s criminalization of intentional transmission of HIV is perhaps its most controversial provision, but may also be one of the easiest to dispense with in favor of alternate legislation. The strong preference of the UNAIDS Reference Group on HIV and Human Rights is that existing criminal laws be used to address cases of intentional and actual transmission of HIV, instead of creation of HIV-specific laws that criminalize HIV-related behaviors. Uganda itself provides a case in point: Even without HIV control legislation, Ugandan courts are already dealing with cases of willful spread of HIV. For example, a man was recently sentenced to 14 years of imprisonment for having sex with a mentally ill 19-year-old girl and infecting her with HIV/AIDS.

With the urging of women’s advocacy organizations like the Law and Advocacy for Women in Uganda (LAW-U), and the

135. HRW Comments, supra note 108.
136. Statement on Criminalization, supra note 124, at 1.
Federation of Women Lawyers — Uganda (FIDA-U), the Ugandan Parliament has made remarkable progress in the past few years in combating forms of gender-based violence — many of which are linked to HIV transmission. As such, these provisions may also contribute to the public health goals of HIV prevention and control.

A. Existing Laws Which Directly or Indirectly Further HIV Prevention Goals

Instead of enacting legislation that broadly criminalizes intentional transmission of HIV, the Ugandan Parliament can build on its existing penal laws and provide enhanced sentencing where HIV is transmitted in the course of already-criminal activity. Recent Ugandan legislation that may already serve HIV prevention goals include:

- **Penal Code Amendment Act (2007)** — Section 129 of the Penal Code Act was amended to create an aggravated class of defilement offence. Defilement is “aggravated” where the victim is less than 14 years old, where the perpetrator is a parent or guardian of the victim or is a serial offender, or where the perpetrator knows him or herself to be infected with HIV.138 It is a felony. The enhanced sentencing triggered by the HIV-status of the offender has generated some concern from advocates who are wary of increasing stigmatization of HIV-positive people.139 However, children’s rights activists hope the law will deter HIV-positive people from preying on virgins to “cure” themselves of HIV.140

- **Prohibition of Female Genital Mutilation Bill (2009)** — In addition to criminalizing FGM in Uganda, this legislation introduces the crime of “Aggravated Female Genital Mutilation” where “the victim is infected with HIV/AIDS as a result of the act of Female Genital Mutilation.”141

---


139. OPEN SOCIETY INSTITUTE, supra note 134, at 10.


Domestic Violence Bill (2009) — This long-awaited piece of legislation, passed in November, 2009, finally renders domestic violence a crime in Uganda. The law takes an expansive view of "domestic relationships" as including any family relationship, "a relationship akin to a family relationship", or a "relationship in a domestic setting that exists or existed between a victim and a perpetrator." It also defines domestic violence as including physical and nonphysical harm. While there is no explicit mention of "marital rape," the law's provisions encompass sexual violence at the hands of a family member (presumptively including spouse) within the scope of the offence. Finally, the law provides for a clear process of complaint available to victims of domestic violence, incorporating law enforcement, local councils, and the formal judiciary, and also provides for the issuance of protection orders to keep abusers away from their victims.

B. Gaps in Existing Law Which, if Addressed, Would Serve Goals of HIV Prevention

There are still a number of areas in which law could be strengthened to protect Ugandan women and reduce their vulnerability to both violence and HIV infection. As a start, the Ugandan Parliament could reform at long last the laws governing divorce, criminal adultery provisions, and succession rights that were all deemed gender-discriminatory and unconstitutional by the Ugandan Constitutional Court in 2003 and 2006. The Parliament has been considering the Marriage and Divorce Bill (2009), the current incarnation of the Domestic Relations Bill which unsuccessfully sought to unify legislation of all family matters —

---

143. The Domestic Violence Bill, cl. 6-18, (2009), in possession of author.
144. See Uganda Women Lawyers Ass'n & 5 others v. Attorney Gen. of Uganda, Constitutional Petition No. 2/03, Judgment of Mpangi-Gahigeine JA, 7 (2004), in possession of author. See also Law & Advocacy For Women in Uganda v. Attorney Gen. of Uganda, Constitutional Petition Nos. 13/05 & 05/06, in possession of author.
marriage, divorce, inheritance of property — under one code.145 Whether Ugandan legislators proceed with the Marriage and Divorce Bill or not, meaningful protection of women’s property and inheritance rights should be a priority if the government wishes to mitigate both women’s risk of HIV infection and their ability to independently obtain care if they do become infected.

VII. Conclusion

Though gender-based violence certainly does not account for all HIV transmission occurring in Uganda today, it is increasingly clear from both human rights and public health perspectives that GBV may render a significant number of Ugandan women vulnerable to HIV infection. Similarly, advocates on the ground indicate that HIV-positive status has marked many women for severe stigmatization, physical abuse, and property grabbing. The connection is significant insofar as women’s health outcomes are directly tied to their security of person — women subjected to gender-based violence are vulnerable to HIV infection, and HIV-positive women who suffer violence or eviction due to their health status face often insurmountable obstacles to obtaining health care.

While the current HIV and AIDS Prevention and Control Bill (2009) contains a number of helpful provisions and protections that would benefit women, these proposed benefits are outweighed by testing, disclosure, and criminalization provisions that contravene international guidelines based on human rights principles. These provisions do not account for nuanced realities of HIV transmission in gender-imbalanced intimate relationships, and may instead negatively impact women.

On the other hand, the Ugandan Parliament has shown robust activity in the passage of recent laws protecting women from gender-based violence (such as FGM, domestic violence, etc.). Targeting the gender inequities that lie at the heart of many women’s risk of HIV may prove to be a better approach than pursuing HIV-specific legislation. Further, improving women’s ability to vindicate property and divorce rights is critical to helping women leave high-risk relationships and support themselves in the event of HIV-infection. In these ways, HIV prevention can actually

be served through legislation aimed principally at combating gender-based violence.

Should the Ugandan Parliament pursue the development of an HIV-specific law at all, it should revise the clauses regarding testing, disclosure, and criminalization after close consideration of their likely disparate impact on women, as well as international standards that reflect human rights norms. It is similarly critical that any HIV control legislation be accompanied by laws strengthening women’s rights — and measures that actually improve women’s access to those rights. Further, it is imperative that as the HIV Bill is refined, more voices from the women’s rights and PLWHA rights communities be heard in consultation. Without full consideration of women’s human rights, Uganda’s HIV bill may in fact harm many among the most vulnerable populations it seeks to protect.