UGANDA DOMESTICATION GUIDE

MAPUTO PROTOCOL

Article 14

MEWC
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SOLIDARITY FOR AFRICAN WOMEN'S RIGHTS
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MOUVEMENT DE SOLIDARITÉ POUR LES DROITS DES FEMMES AFRICAINES
Une force pour la liberté

SIHA Network
Strategic Initiative for Women in the Horn of Africa

AKINA MAMA WA AFRIKA

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Introduction

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, widely known as the Maputo Protocol, stands as one of the most progressive human rights instruments in the world. Adopted by the African Union in 2003, it sets out a bold vision for the dignity, equality, and bodily autonomy of women and girls across the continent. For the millions of women it seeks to protect, the Protocol is more than a legal text. It is a promise.

This guide is produced by Make Every Woman Count (MEWC) and the Solidarity for African Women's Rights Coalition (SOAWR). It offers a practical path from international and regional commitment to national reality grounding the Protocol's standards in the specific legal, political, and social context of this country.

Why the Maputo Protocol Matters

At the heart of this guide is one of the Protocol's most significant provisions: Article 14 guarantees women's reproductive health rights, including access to family planning, safe maternal care, and lawful abortion in cases of sexual assault, rape, incest, or when a pregnancy endangers a woman's mental or physical health.

This article addresses some of the biggest threats women face: preventable maternal deaths, unsafe abortions, gender-based violence, and barriers that deny women control over their own bodies. The Protocol frames these issues not as matters of charity or moral debate, but as enforceable human rights.

Understanding 'Domestication'

A treaty only changes lives when its standards reach the people it protects. Domestication is the process of translating international obligations into national law, policy, and practice so that rights become enforceable in domestic courts and through everyday government services. How this happens depends on a country's legal system:

In monist states, ratified treaties are, in principle, directly applicable and take precedence over national law. Yet in practice, domestic courts and institutions rarely apply these standards, leaving a gap between theory and reality.

In dualist states, treaties do not become law on ratification alone. They require a deliberate act of Parliament to be incorporated and enforced. Until that happens, the Protocol's promises remain aspirational.

In both systems, domestication is the bridge between commitment and lived experience. Closing that gap is the central purpose of this guide.

I. Purpose of This Guide and How to Use It

This Domestication Guide is designed to support advocates, parliamentarians, civil society organisations, legal practitioners and policymakers working to advance the full domestication of Article 14 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol) in Uganda, with a particular focus on reproductive justice. In Uganda, where reproductive rights remain legally and politically contested, this guide provides a practical tool to support informed advocacy, legal reform and implementation efforts.[1] The Maputo Protocol, adopted by the African Union (AU) on 11 July 2003 and in force since 25 November 2005, is widely regarded as the most progressive legal instrument for women's rights in Africa. Uganda signed the Protocol on 16 December 2003 and ratified it on 22 July 2010, thereby undertaking to respect, protect and fulfil the rights contained therein.[2]

Article 14(1) of the Protocol guarantees women's right to health, including sexual and reproductive health. Under Article 14(2), State Parties must take specific measures, including (a) providing adequate, affordable and accessible health services; (b) establishing and strengthening pre-natal, delivery and post-natal health and nutritional services for women; and (c) authorising medical abortion in cases of sexual assault, rape or incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus. Beyond abortion access, Article 14 also protects broader reproductive rights relating to dignity, bodily autonomy, informed decision-making and access to comprehensive sexual and reproductive healthcare services.

This guide adopts a reproductive justice approach in analysing the domestication of Article 14 in Uganda. Reproductive justice extends beyond abortion access and includes the right to have children, the right not to have children and the right to raise children in a safe, healthy and supportive environment. In the Ugandan context, this approach provides a broader framework for understanding bodily autonomy, reproductive decision-making, access to healthcare services and the structural inequalities that shape women's reproductive lives

II. Country Context and Legal Framework

Uganda is a landlocked country in East Africa with a population of approximately 45 million people, governed under a presidential system. Since the adoption of the 1995 Constitution, Uganda has maintained a constitutional order that provides for the protection of fundamental rights and freedoms, including the rights of women.[3]

The country is a member of the AU, the East African Community (EAC) and the Intergovernmental Authority on Development (IGAD), and is party to several regional and international human rights instruments. These commitments place obligations on the state to promote, protect and fulfil human rights, including rights relating to reproductive justice, bodily autonomy, gender equality and access to healthcare.[4] English is the official language, with Kiswahili and a range of indigenous languages widely spoken across the

country. Uganda is characterised by significant cultural, ethnic and religious diversity, which continues to shape social norms, legal interpretations and policy approaches, particularly in relation to gender equality and reproductive rights.[5]

Legal System and Domestication of International Treaties

Uganda is a dualist state. In a dualist system, international treaties do not automatically become part of domestic law upon ratification; rather, they require a distinct Act of Parliament to have domestic legal force.[6] This is in contrast to the situation in monist systems, such as Cameroon's, where treaties are directly applicable upon ratification and publication. Uganda ratified the Maputo Protocol on 22 July 2010. However, it has not been fully domesticated into national legislation. As a result, while Uganda is bound by the obligations of the Protocol under international law, the provisions of Article 14 are not directly enforceable in domestic courts unless incorporated into national law.

The Constitution of the Republic of Uganda, 1995 (as amended), provides the primary legal framework for the protection of women's rights.[7] Article 21 guarantees equality and freedom from discrimination, while Article 33 specifically recognises the rights of women and obliges the state to recognise women's maternal function and take affirmative action to address historical inequalities. Furthermore, Article 45 provides that the rights, duties, declarations and guarantees relating to fundamental and other human rights shall not be regarded as excluding others not specifically mentioned.

However, the Conclusion places limitations on reproductive rights; a case in point is Article 22(2), which provides that 'no person has the right to terminate the life of an unborn child except as may be authorised by law.' This provision has contributed to restrictive interpretations of abortion law and creates ambiguity regarding the scope of reproductive rights under domestic law. Therefore, the key question for Uganda regarding the domestication of Article 14 of the Maputo Protocol is whether it is effectively applied in courtrooms, health facilities, policy documents and public institutions.

Key Institutional Stakeholders

The domestication landscape involves several key actors. The Ministry of Health is responsible for policy development and the implementation of reproductive health services, while the Ministry of Gender, Labour and Social Development oversees gender equality and women's empowerment initiatives. The latter also plays a central role in the general implementation of the Maputo Protocol and serves as the line ministry responsible for state reporting to the African Commission on Human and Peoples' Rights (ACHPR).[8] Furthermore, the Ministry of Finance, Planning and Economic Development must be actively involved in the process to ensure adequate the proper allocation of adequate financial resources. Without this crucial step and the necessary budgetary provisions, there will be no funds available to carry out domestication of the Maputo Protocol.[9]

The judiciary has the constitutional mandate to interpret, apply and enforce the law, including provisions relating to reproductive rights.[10] The Uganda Human Rights Commission also plays an important role in monitoring compliance with human rights obligations and

addressing violations.[11] The legal profession and civil society are also key actors in the domestication process. Organisations such as the Center for Health, Human Rights and Development (CEHURD), Reproductive Health Uganda (RHU) and the Women's Probono Initiative are actively involved in advocacy, strategic litigation and public awareness on reproductive rights.[12] Faith-based institutions and traditional leaders also exercise significant influence over public attitudes towards reproductive rights, particularly in relation to abortion, and continue to shape policy debates and implementation.[13]

III. Status of Domestication

The Legal and Policy Baseline

The Maputo Protocol became binding on Uganda upon ratification. However, Uganda's dualist legal system means it does not automatically have the force of domestic law, and requires legislative incorporation to be directly enforceable. As a result, the provisions of Article 14 are not directly enforceable unless incorporated into national legislation, although Ugandan courts have increasingly relied on the Protocol as an interpretive tool. This means the legal framework is not fully operational and requires further legislative and policy action.

Uganda signed the Protocol on 16 December 2003, ratified it on 22 July 2010 and deposited its instrument of ratification with the AU shortly thereafter.[14] The Protocol entered into force for Uganda following ratification. Although, as we have seen, Uganda operates under a dualist legal system and the Maputo Protocol has not been fully incorporated into domestic legislation through a specific Act of Parliament, Ugandan courts have increasingly relied on the Protocol in interpreting constitutional rights and advancing women's rights jurisprudence.[15] Judicial decisions have demonstrated growing recognition that ratification reflects the state's intention to be bound by the Protocol, subject to Uganda's reservations to Articles 14(1)(a) and 14(2)(c).

Ugandan courts have relied on the Maputo Protocol in several important cases. In *Mifumi (U) Ltd & Others v Attorney General*, the Supreme Court relied on Article 6 of the Maputo Protocol in declaring the practice requiring the refund of bride price unconstitutional.[16] In *Center for Domestic Violence Prevention (CEDOVIP) & Others v Attorney General*, the Constitutional Court relied on Articles 2 and 4 of the Protocol in striking down provisions of the Anti-Pornography Act that criminalised women's dress.[17] In *Law and Advocacy for Women in Uganda v Attorney General*, the Constitutional Court relied on Article 5 of the Protocol in addressing the practice of female genital mutilation/cutting.[18] Similarly, in *CEHURD & Others v Attorney General*, the Constitutional Court engaged with principles relating to maternal healthcare rights that align with the objectives of Article 14 of the Maputo Protocol.[19]

The Legal and Policy Position on Article 14

Uganda entered reservations to Articles 14(1)(a) and 14(2)(c) of the Maputo Protocol. In relation to Article 14(1)(a), Uganda indicated that it would interpret the provision in a

manner that excludes rights associated with abortion and maintains state control over family planning matters.[20] Uganda also entered a reservation to Article 14(2)(c), stating that abortion would be permitted only in accordance with national laws. These reservations significantly affect the scope and implementation of reproductive rights under the Protocol within the Ugandan context and remain a central consideration in domestication efforts.[21] In practice, the implementation of Article 14, particularly Article 14(2)(c), continues to be constrained by constitutional provisions, domestic legal frameworks and Uganda's reservations to the Maputo Protocol.

Article 22(2) of the Constitution provides that 'no person has the right to terminate the life of an unborn child except as may be authorised by law,' which has contributed to restrictive interpretations of abortion law. The Penal Code Act criminalises abortion except under limited circumstances, but does not clearly define the scope of lawful abortion. This lack of clarity creates uncertainty for healthcare providers, law enforcement officials and women seeking services. As a result, even where abortion may be legally permissible, it is often inaccessible in practice.[22] The existence of reservations to key reproductive rights provisions of the Maputo Protocol further complicates domestication efforts, as they limit the extent to which courts and policymakers may rely directly on Article 14 in advancing reproductive justice protections.[23]

Judicial interpretation has also reflected the tensions surrounding reproductive rights in Uganda. In *Human Rights Awareness and Promotion Forum (HRAPF), CEHURD & Others v Attorney General*, the Constitutional Court considered the constitutionality of abortion-related criminal provisions and held that the criminalisation of abortion was consistent with Uganda's constitutional values, morality and public policy considerations.[24] However, the case also included a dissenting judgement, illustrating ongoing judicial and societal contestations surrounding reproductive rights and bodily autonomy in Uganda.

In addition, policy guidance has been inconsistent. The Ministry of Health issued guidelines on safe abortion in 2015; however, these were subsequently withdrawn, creating a gap in clinical and legal guidance.[25] In practice, this has led to a situation where healthcare providers are reluctant to offer abortion services, and women face significant barriers in accessing safe and legal abortion care.[26]

Progress since Ratification

Since ratifying the Maputo Protocol in 2010, Uganda has made incremental but uneven progress on aspects of Article 14, particularly on maternal health, protection from violence, prohibition of harmful practices and broader gender equality frameworks. While these developments do not amount to full domestication, they reflect partial alignment with the objectives of the Protocol and demonstrate a growing, albeit cautious, engagement with reproductive health as both a rights-based and a public health concern. At the policy level, Uganda has implemented several measures aimed at improving maternal health outcomes, including successive National Development Plans (NDP II and NDP III), the Health Sector Development Plan and national sexual and reproductive health strategies that prioritise access to pre-natal, delivery and post-natal care services.[27] Although progress has been uneven and often constrained by resource limitations and systemic

challenges, these policy commitments signal an increasing recognition of the importance of reproductive health within national development and public health frameworks.

Legislative developments have also contributed indirectly to advancing elements of Article 14, particularly those relating to bodily integrity and protection from harmful practices. The enactment of laws such as the Domestic Violence Act (2010), the Prohibition of Female Genital Mutilation Act (2010),and the Prevention of Trafficking in Persons Act (2009) reflects important progress in addressing forms of violence and exploitation that undermine women's autonomy and reproductive health.[28] These laws provide a legal basis for protecting women and girls from practices that have significant implications for their physical and reproductive wellbeing. Judicial developments have also contributed to the domestication of the Maputo Protocol in Uganda. Ugandan courts have increasingly relied on the Protocol in cases concerning bride price, female genital mutilation/cutting, maternal healthcare rights and women's bodily autonomy, thereby strengthening the recognition of regional women's rights standards within domestic jurisprudence. However, their effectiveness is closely tied to enforcement, institutional capacity and public awareness, all of which remain uneven across different regions and communities.

Within Uganda's institutional framework, there is no single authority specifically mandated to oversee the domestication and implementation of the Maputo Protocol. Instead,[29] responsibility is dispersed across multiple institutions, including the Ministry of Gender, Labour and Social Development, the Uganda Human Rights Commission and the Ministry of Health. While these institutions play important roles in promoting gender equality, monitoring human rights and delivering health services, their efforts are often constrained by limited resources, weak coordination and gaps in accountability.[30] The absence of a dedicated mechanism for overseeing implementation has contributed to fragmented domestication efforts, with limited coherence across legal, policy and service delivery levels.

Judicial engagement has provided an important, though still emerging, avenue for advancing reproductive rights within the domestic legal framework. Ugandan courts have increasingly addressed issues related to maternal health and the right to health, contributing to the gradual recognition of reproductive health as a justiciable concern. In *CEHURD& Others v Attorney General*, Issues 3, 4, and 5 of the judgement addressed the state's obligations in relation to maternal healthcare and the constitutional implications of failures in service delivery.[31] The case underscored that inadequate maternal healthcare services may give rise to violations of constitutional rights, including the rights to life and dignity.[32] While the case did not directly invoke Article 14 of the Maputo Protocol, it represents a significant development in strengthening the legal basis for reproductive health rights and creates opportunities for future litigation to further align domestic jurisprudence with regional human rights standards.

In practice, however, much of the sustained progress in advancing aspects of Article 14 has been driven by civil society rather than the state. Organisations such as CEHURD, RHU and the Women's Probono Initiative have played a central role in advocacy, strategic litigation, service provision,and public education.[33] These actors have been instrumental in raising awareness, supporting access to services and holding the state accountable for gaps

in implementation. At the same time, civil society organisations in Uganda often operate within constrained environments characterised by limited funding, political sensitivities and regulatory challenges, which can affect the sustainability and reach of their interventions.[34]

Despite these areas of progress, sociocultural and religious norms continue to exert a strong influence on reproductive rights in Uganda. Public attitudes towards issues such as abortion are frequently shaped by moral and religious considerations, contributing to stigma, silence and resistance to reform.[35] These dynamics influence both policy development and service delivery, often limiting the effectiveness of existing legal and policy frameworks. Empirical evidence further indicates that stigma, discrimination and social norms continue to restrict access to reproductive health services, particularly for young people and unmarried women.[36] In many cases, these barriers are reinforced by institutional practices, including judgemental attitudes among healthcare providers and informal restrictions on access to services.

At the same time, public health data highlight the consequences of these limitations. Unsafe abortion remains a significant contributor to maternal morbidity and mortality in Uganda, reflecting both restricted access to safe services and broader systemic challenges within the healthcare system.[37] These realities underscore the gap between legal and policy commitments on the one hand and lived experiences on the other. They also illustrate that progress in certain areas has not yet translated into comprehensive protection of reproductive rights.

Overall, progress since ratification can be characterised as incremental but incomplete. Uganda has made important advances in policy development, legislative protection against harmful practices and judicial recognition of reproductive health as a rights issue. However, these gains have not yet coalesced into a coherent and fully realised system of reproductive rights protection. Persistent challenges, including legal ambiguity, institutional fragmentation and sociocultural resistance, continue to limit the full domestication of Article 14. This mixed picture of progress highlights the need for a more coordinated and strategic approach moving forward, one that builds on existing developments while addressing the structural barriers that continue to constrain implementation.

Gaps and Barriers

Legal and Policy Gaps and Barriers

The most significant legal constraint on the domestication of Article 14 in Uganda is the state's own reservations to the Maputo Protocol. Uganda entered reservations to Articles 14(1)(a) and 14(2)(c) upon ratification in 2010, indicating that it would interpret the right to control fertility in a manner that excludes abortion and maintains state control over family planning matters, and that abortion would only be permitted in accordance with national law.[38] These reservations directly limit the scope of reproductive rights protections available to women under the Protocol within the Ugandan legal framework, and represent a formal refusal to be bound by the most progressive reproductive rights provisions of the instrument.[39] In 2024, the ACHPR plicitly called on Uganda to withdraw its reservation on Article 14 of the Maputo Protocol, underscoring its incompatibility with Uganda's broader

human rights obligations.[40] The International Commission of Jurists (ICJ) has similarly submitted that Uganda's reservations are inconsistent with the object and purpose of the Protocol, and that the domestic legal framework should be reformed in a manner that progressively reduces their practical effect.[41]

The reservations interact with and reinforce a set of domestic legal barriers that compound their restrictive impact. The Penal Code Act criminalises abortion and remains largely inconsistent with Article 14(2)(c) of the Maputo Protocol.[42] Although the Constitution permits termination of pregnancy where authorised by law, the absence of clear, comprehensive legislation defining the circumstances under which abortion is lawful has created a restrictive and uncertain legal environment. The Penal Code criminalises abortion for both the woman and any person assisting her, with limited and narrowly interpreted exceptions. While case law and policy discussions have suggested that abortion may be permissible to save the life or preserve the health of the woman, these grounds are not clearly codified or consistently applied in practice. The broader grounds recognised under Article 14(2)(c), including rape, incest, threats to mental health and foetal impairment, are not explicitly reflected in Uganda's statutory framework.[43]

The absence of clear legal provisions is compounded by policy inconsistency. The withdrawal of the Ministry of Health's 2015 guidelines on safe abortion has left healthcare providers without authoritative clinical and legal guidance.[44] This has created a chilling effect, whereby providers are reluctant to offer services owing to fear of legal repercussions, even in cases where abortion may be permissible. Furthermore, Uganda has not established comprehensive accountability mechanisms, implementation standards or accessible redress mechanisms for violations of sexual and reproductive health rights, as required under ACHPR General Comment No. 2.[45] This limits women's ability to seek remedies and reinforces the gap between legal obligations and lived realities.

Sociocultural and Religious Gaps and Barriers

Stigma surrounding abortion remains pervasive in Uganda. Women and girls often seek abortion services in secrecy owing to fear of social exclusion, shame and community backlash. This contributes to the prevalence of unsafe abortion practices, even in circumstances where legal exceptions may exist.[46] Religious institutions and cultural leaders play a significant role in shaping public attitudes and policy discourse on reproductive rights. In many cases, conservative interpretations of religious doctrine influence political will and limit support for legal reform.[47] These actors can mobilise strong opposition to changes perceived to conflict with moral or religious values. These challenges are further compounded by growing backlash against gender equality and sexual and reproductive health and rights, driven by anti-rights actors and conservative movements that seek to restrict women's bodily autonomy and reproductive decision-making through religious and moral frameworks.[48] In some instances, these actors have increasingly influenced political and legislative processes, reinforcing resistance to reproductive justice reforms. More broadly, sociocultural and religious norms continue to shape women's access to sexual and reproductive healthcare services, including contraception, reproductive information, maternal healthcare and reproductive decision-making.[49] These barriers disproportionately affect young women, unmarried women and women in rural communities.

Low levels of public awareness regarding reproductive rights, including the provisions of the Constitution and the Maputo Protocol, further exacerbate these challenges. Many women, as well as healthcare providers, are unaware of the circumstances under which abortion may be legally permissible, leading to underutilisation of existing legal space and reinforcing barriers to access.[50]

Institutional and Structural Gaps and Barriers

A significant barrier to the domestication of Article 14 in Uganda is the limited awareness and understanding of the Maputo Protocol among key stakeholders, including healthcare providers, legal practitioners and public officials.[51] The dualist nature of the legal system further complicates the situation, as the Protocol is not widely recognised as a directly applicable legal instrument.[52] Uganda continues to face challenges in maternal health outcomes, with the maternal mortality ratio estimated at 189 deaths per 100,000 live births in 2022, remaining significantly above the Sustainable Development Goal target of 70 deaths per 100,000 live births.[53] Unsafe abortion continues to contribute significantly to preventable maternal deaths and complications.[54] While efforts have been made to improve access to family planning services, the unmet need for contraception remains high, particularly among young women and those in rural areas. Structural inequalities, including poverty, rural healthcare disparities, gender inequality and limited access to reproductive health information, further undermine women's ability to exercise reproductive autonomy and access comprehensive sexual and reproductive healthcare services.

Institutional capacity constraints also affect implementation. Health facilities, especially in rural and underserved regions, often lack the resources, trained personnel and infrastructure necessary to provide comprehensive sexual and reproductive health services.[55]

Judicial engagement with reproductive rights remains limited, and there is no structured or systematic training programme for judges and legal practitioners on the application of international human rights instruments, including the Maputo Protocol.[56] As a result, opportunities to invoke Article 14 in litigation are not fully utilised. Civil society organisations play a central role in advancing reproductive rights, but coordination among actors remains a challenge. While organisations such as CEHURD, RHU and others are actively engaged in advocacy and service provision, greater collaboration and networking would strengthen collective efforts to promote legal reform and improve access to services.[57]

Opportunities

Reservations and Opportunities for Legal Reform

Uganda's reservations to Articles 14(1)(a) and 14(2)(c) of the Maputo Protocol remain significant considerations in the domestication process. The reservations limit the direct application of certain reproductive rights protections under the Protocol, particularly those relating to abortion and reproductive autonomy.[58] As a result, domestication efforts must engage not only with domestic legal and policy barriers but also with the implications of these reservations for the implementation of Article 14.[59]

Despite these challenges, important opportunities for legal reform remain. Article 22(2) of the Constitution permits termination of pregnancy 'as may be authorised by law,' creating space for legislative clarification and reform. This provides an opportunity for Uganda to enact a comprehensive legal framework regulating lawful abortion in a manner that aligns with Article 14(2)(c) of the Maputo Protocol. Similarly, reform or amendment of restrictive provisions within the Penal Code Act could help bring domestic law into closer conformity with regional human rights standards.[60]

These developments not only would strengthen reproductive justice protections within Uganda but also could reduce the practical significance of the reservations over time.[61] In this regard, domestication should be understood as an ongoing process involving legal reform, judicial engagement, policy development and broader societal transformation.

Judicial engagement also presents important opportunities for advancing domestication. Ugandan courts have increasingly relied on the Maputo Protocol in interpreting constitutional rights and advancing women's rights jurisprudence, including in cases relating to bride price, female genital mutilation/cutting, women's bodily autonomy and maternal healthcare rights.[62] This growing body of jurisprudence provides an important foundation for future litigation and advocacy aimed at strengthening the implementation of Article 14 within the Ugandan legal system.

Regional and Comparative Precedents

Experiences from other African jurisdictions provide important opportunities for Uganda. Countries such as Rwanda and Democratic Republic of Congo (DRC) demonstrate that progressive domestication of Article 14 is both achievable and sustainable when supported by coordinated advocacy and political will.[63]

Rwanda's trajectory is particularly instructive. Following sustained advocacy by civil society and international actors, Rwanda withdrew its reservation to Article 14(2)(c), and it subsequently enacted legislation expanding access to safe abortion, including in cases of sexual violence and health risks. This demonstrates the importance of long-term advocacy combined with legislative reform.[64]

Similarly, DRC offers a model of step-by-step domestication. After ratification, the Protocol was formally published in the national legal gazette, and followed this with the development of national guidelines on abortion care.[65] This process highlights the importance of legal recognition, policy guidance and institutional support in translating international commitments into practice.

For Uganda, these examples provide both technical guidance and political precedent, showing that reform is feasible within African legal and cultural contexts.

African Human Rights Framework and Normative Support

The ACHPR has developed a robust normative framework supporting the domestication of Article 14, which provides advocates, legal practitioners and policymakers with authoritative tools for advancing reform.

In particular, General Comment No. 2 (2014) on Article 14(1)(a), (b), (c) and (f) and Article 14(2)(a) and (c) of the Maputo Protocol remains the foundational interpretive instrument, providing authoritative guidance on the obligations of State Parties regarding sexual and reproductive health rights.[66] The Comment requires states to ensure access to safe abortion within the grounds set out in Article 14(2)(c), remove barriers restricting access to lawful services, establish accountability mechanisms for violations and provide clear guidelines for healthcare providers. These standards allow civil society actors and legal practitioners in Uganda to frame demands for reform as existing obligations rather than aspirational requests.[67]

The normative framework has been substantially strengthened by recent continental developments. In 2024, the ACHPR adopted Resolution ACHPR/Res.592 (LXXX), calling for the development of a Model Law on the Implementation and Domestication of the Maputo Protocol, explicitly intended to guide national legislatures in harmonising domestic law with the Protocol\s provisions.[68] Building on this, in 2025, it adopted Resolution ACHPR/Res.632 (LXXXII) on the need to raise awareness for states to withdraw reservations on some provisions of the Protocol, directly addressing the nine State Parties, including Uganda, that retain reservations.[69] It subsequently mandated its Special Rapporteur on the Rights of Women in Africa to develop the Advocacy Framework for Withdrawing Reservations to Some Provisions of the Maputo Protocol, adopted at the 86th Ordinary Session in 2026.[70] This Framework provides a systematic, stakeholder-specific set of strategies for withdrawal of reservations, drawing on precedents including Rwanda and The Gambia, and identifying concrete entry points for State Parties, civil society, national human rights institutions (NHRIs) and regional bodies.

The ACHPR has also engaged Uganda specifically. In its 2024 Concluding Observations on Uganda's Combined Sixth to Eighth Periodic Report, it called on Uganda to withdraw its reservation on Article 14 of the Maputo Protocol, though without elaborating its reasons.[71] Advocates can use this recommendation as a concrete, government-directed accountability tool in engagement with Parliament, line ministries and the Uganda Human Rights Commission.

In addition, engagement with regional mechanisms, including state reporting, shadow reporting and the Universal Periodic Review, provides structured opportunities to hold Uganda accountable and generate sustained pressure for reform.[72] The reproductive justice framework further enables more holistic advocacy approaches that connect legal reform with broader questions of healthcare access, social justice, gender equality and bodily autonomy, grounding domestic arguments in a well-established international normative tradition.

Civil Society Networks and Advocacy Platforms

Uganda benefits from a relatively strong civil society ecosystem working on health, gender equality and human rights. Organisations such as CEHURD, RHU and the Women's Probono Initiative are actively engaged in advocacy, litigation and service provision.[73]

These organisations are also connected to broader continental networks such as SOAWR, which provides access to:

- Shadow reporting mechanisms;
- Legal and policy resources;
- Peer learning opportunities;
- Regional advocacy platforms.[74]

This networked approach enhances the effectiveness of national advocacy by linking it to continental movements and international accountability frameworks. It also provides opportunities for capacity-building and knowledge-sharing.

IV. Advocacy and Lobbying Strategies

What Has Worked Within Uganda

Strategic litigation has played an important role in advancing accountability in maternal health and reproductive rights. Cases such as *CEHURD & Others v Attorney General* have highlighted the state's obligations to provide essential health services and prevent avoidable maternal deaths.[75] While such cases have not directly addressed abortion access, they have established important principles regarding state responsibility and the justiciability of health rights. Civil society advocacy has also been effective in raising awareness, documenting violations and engaging policymakers. Campaigns focusing on maternal health, gender-based violence and access to healthcare have contributed to incremental policy changes and increased public discourse on reproductive rights.[76]

Multi-sector engagement has proven particularly effective. Initiatives that bring together healthcare providers, legal practitioners, community leaders and policymakers have helped build consensus and reduce resistance to reform.[77]

Regional Lessons

Regional experiences highlight the importance of sustained and coordinated advocacy. Rwanda's reforms demonstrate the value of long-term engagement with policymakers, while DRC's approach underscores the importance of institutionalising legal commitments through publication and policy development.[78]

These examples also show political will is not static; it can be influenced through strategic advocacy, coalition building and evidence-based arguments.

Lessons Learned

- Legal ambiguity can be as restrictive as prohibition: Where the law is unclear, providers and women are likely to avoid engaging with it, leading to reduced access in practice.[79]
- Policy clarity is critical: The withdrawal of abortion guidelines in Uganda illustrates how policy gaps can undermine implementation.[80]

- Judicial engagement requires capacity-building: Courts are unlikely to apply international standards without training and awareness.
- Fragmentation weakens advocacy: Coordinated civil society efforts are more effective than isolated initiatives.[81]
- Sociocultural engagement is essential: Reform efforts must address stigma and engage religious and community leaders.[82]

Strategies for Effective Domestication

Legal advocacy remains central to advancing the domestication of Article 14 of the Maputo Protocol. Stakeholders should promote incremental legislative reform that clarifies the scope of lawful reproductive health services, particularly under Article 14(2)(c). In parallel, there is a need to strengthen rights-based judicial interpretation of existing laws in line with international obligations.[83] Regional human rights instruments, including the Maputo Protocol, should be used as advocacy and interpretive tools to support this process. [84]

Stakeholder Engagement

Effective domestication requires coordinated engagement among key actors. Civil society organisations should strengthen collaboration and coalition-building to enhance the impact of advocacy efforts.[85] Targeted engagement with Parliament and policymakers is essential, supported by evidence-based arguments. Leveraging regional networks can also strengthen advocacy and accountability.[86]

Capacity-Building

Capacity-building is critical to ensuring effective implementation. Training healthcare providers, legal practitioners and judicial officers can improve understanding and application of reproductive rights. At the same time, clear guidelines should be developed and disseminated to support consistent service delivery. Strengthening institutional capacity, particularly in the health sector, remains essential.[87]

V. New and Emerging Approaches

Advocates are deploying a range of targeted strategies to advance domestication of Article 14 in Uganda, moving beyond general awareness-raising towards concrete legal and institutional change.

The most significant emerging development is the growing continental movement to frame withdrawal of reservations as a concrete, achievable objective. The ACHPR's 2026 Advocacy Framework for Withdrawing Reservations provides civil society and NHRIs with a structured tool for engaging governments on reservation withdrawal, drawing on precedents such as Rwanda's 2012 withdrawal of its reservation to Article 14(2)(c) following sustained civil society advocacy.[88],[89] For Uganda, this Framework provides both a normative basis and a practical template for advocacy directed specifically at Articles 14(1)(a) and 14(2)(c).

Rather than advancing reproductive rights through direct liberalisation arguments, advocates are increasingly framing demands as matters of treaty compliance and constitutional conformity. Article 22(2) of Uganda's Constitution already permits abortion 'as may be authorised by law,' providing a domestic legal hook for arguing that Parliament is constitutionally empowered to enact legislation giving effect to Article 14(2)(c). The ACHPR used this same constitutional compatibility argument when calling on Kenya to withdraw its equivalent reservation.[90]

Strategic litigation and shadow reporting offer further entry points. Cases such as *CEHURD v Attorney General* have established justiciable principles around state obligations on maternal health, laying groundwork for future reproductive rights litigation.[91] Civil society engagement with the ACHPR's periodic reporting cycle, supported by SOAWR's technical platforms, has already produced concrete accountability outputs, including the ACHPR's 2024 Concluding Observations explicitly calling on Uganda to withdraw its Article 14 reservation.[92]

Finally, faith-based engagement is increasingly recognised as essential rather than optional. Evidence from Kenya and Zambia demonstrates that reproductive health advocacy grounded in scriptural frameworks around protection of life and maternal welfare can reach policymakers and communities that secular human rights arguments do not, building broader coalitions for reform.[93]

VI. Next Steps and Actionable Recommendations

For Parliamentarians and Policymakers

Parliamentarians and policymakers play a critical role in advancing the domestication and implementation of Article 14 of the Maputo Protocol in Uganda. As a priority, Parliament should initiate a review of Uganda's reservations to Articles 14(1)(a) and 14(2)(c) of the Maputo Protocol with a view to their progressive withdrawal. This process should involve consultations with relevant ministries, civil society organisations, healthcare professionals, religious leaders and women's rights advocates to assess the impact of the reservations on women's reproductive rights and Uganda's compliance with its regional human rights obligations.

Parliament should also consider legislative reforms and policy clarification measures to align domestic laws with Article 14, particularly Article 22(2) of the Constitution and relevant provisions of the Penal Code Act. The Ministry of Health, in collaboration with the Ministry of Gender, Labour and Social Development and the Ministry of Justice and Constitutional Affairs, should develop clear and consistent national guidelines on reproductive healthcare, including lawful abortion services, post-abortion care and reproductive health information.

Policymakers should strengthen access to comprehensive sexual and reproductive health services by increasing budgetary allocations for maternal healthcare, family planning services, reproductive health education and healthcare infrastructure, particularly in underserved and rural communities. In addition, government institutions should establish

monitoring and accountability mechanisms to assess progress in implementing Article 14 obligations and ensure effective coordination between health, gender and justice sectors.

For Civil Society Organisations

Civil society organisations should prioritise advocacy for the review and withdrawal of Uganda's reservations to Articles 14(1)(a) and 14(2)(c) of the Maputo Protocol. This should include engaging Parliament, government ministries, regional human rights bodies and other stakeholders through evidence-based advocacy demonstrating the impact of the reservations on women's health, dignity and bodily autonomy.

Civil society organisations should strengthen coalition-building among women's rights organisations, healthcare professionals, legal practitioners, community leaders and youth organisations to promote a coordinated approach to reproductive justice advocacy. They should also conduct public awareness campaigns to improve understanding of Article 14 and challenge stigma and misinformation surrounding reproductive healthcare services.

Strategic litigation should continue to be utilised to clarify legal ambiguities and advance the interpretation of reproductive rights in line with the Constitution and the Maputo Protocol. Civil society actors should further engage in regional and international reporting processes, including submissions to the ACHPR, to strengthen accountability and encourage implementation of Article 14 obligations.

For the Judiciary

The judiciary plays a critical role in advancing the domestication of Article 14 through rights-based interpretation of domestic law. Courts should interpret constitutional and statutory provisions consistently with Uganda's regional and international human rights obligations, including the Maputo Protocol, and recognise reproductive health as integral to the rights to dignity, equality, health and bodily autonomy.

The Judicial Training Institute and other relevant bodies should strengthen judicial education programmes on the Maputo Protocol, General Comment No. 2 on Article 14 and comparative African jurisprudence on reproductive rights. This would promote greater consistency in judicial decision-making and improve understanding of the regional human rights framework.

Courts should also ensure women and girls are not unfairly criminalised for seeking reproductive healthcare and should interpret legal ambiguities in ways that protect rights, reduce harm and promote substantive gender equality. Through progressive and rights-based jurisprudence, the judiciary can play a significant role in advancing reproductive justice and strengthening the implementation of Article 14 in Uganda.

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