PROTECTION OF THE RIGHT TO HEALTH CARE OF WOMEN LIVING WTH HIV/AIDS (WLA) IN UGANDA

THE CASE OF MBARARA HOSPITAL

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LIST OF ACRONYMS/ABBREVIATIONS

ART	Antiretroviral Treatment
AIDS	Acquired Immune Deficiency Syndrome
ABC	Abstain Be Faithful Use a Condom
ARVs	Antiretroviral
ART	Antiretroviral Therapy
ACHPRq	African Charter on Human and Peoples Rights
CBR	Centre for Basic Research
CSOs	Civil Society Organizations
CESCR	Committee on Economic, Social and Cultural Rights
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
DPSP	Directive Principles of State Policy
GDP	Gross National Product
HIV	Human Immunodeficiency Virus
ICESCR	International Covenant on Economic, Social and Cultural Rights
IBFAN	International Baby Food Action Network
IMF	International Monetary Fund
JCRC	Joint Clinical Research Centre
MFPED	Ministry of Finance, Planning and Economic Development
MTCT	Mother to Child Transmission
NGOs	Non Governmental Organizations
PLHA	Persons Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PEAP	Poverty Eradication Action Plan
RBA	Rights Based Approach
STIs	Sexually Transmitted Infections
Shs	Shillings
THETA	Traditional and Modern Health Practitioners Together against AIDS and other Related Diseases
TASO	The AIDS Support Organization
TBAs	Traditional Birth Attendants
THP	Traditional Health Practitioner
TRIPS	Trade Related Aspects of Intellectual Property Rights
UBOS	Uganda Bureau of Statistics
UHRC	Uganda Human Rights Commission
UN	United Nations
UNDP	United Nations Development Programme
UDHR	Universal Declaration on Human Rights
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNHCHR	United Nations High Commissioner on Human Rights
UAC	Uganda AIDS Commission
UDHS	Uganda Demographic Health Survey

VCT	Voluntary Counseling and Testing
WLA	Women Living with HIV/AIDS
WHO	World Health Organization
WTO	World Trade Organization

LIST OF CASES

Cruz Bermudez et al v. *Ministerio de Sanida Asistentia Social*, Decision no. 91615 (1999).

Keshavananda Bharati v. State of Kerala (1973) 4 SCC 228

Malawi Savings Bank v. Bonny Brighton Kolombola, Civil suit no. 1394 of 1997.

Minister of Health v. Treatment Action Campaign (TAC) (2002) 5 SA 721.

Paschim Banga Khet Mazdoor Sanity and Others v. State of West Bengal (1966) AIRSC 246.

Salvatori Abuki v. Attorney General, Constitutional Petition No. 2 of 1997.

S.Mukwanyane &Anor, (1995) S.A. 391

Social and Economic Rights Action Center (SERAC) and the Center for Economic and Social Rights (CESR) v. Nigeria, Decision Regarding Communication No.155/96, African Commission on Human and Peoples' Rights.

SUMMARY OF THE REPORT AND MAIN RECOMMENDATIONS

The study examines factors that affect protection of the right to health care of Women Living with AIDS (WLA) in Uganda. It recognizes the critical role Anti-retroviral Therapy (ART) plays in the enjoyment of the rights to life and to health of WLA. Through human rights and gender perspectives, the study explores the major constraints to the protection of the right of WLA to access ART. The study does this in the first instance by analyzing the extent to which the legal and policy framework protects this right in Uganda, and delimits the scope, contours and content of the right, with a particular analysis of the situation of Mbarara Hospital in south-western Uganda. Also identified are the obligations of the state and other actors including private persons and the institutions of globalization.

In theory, there is no doubt that WLA have a right of access to health care. However, the realization of this right is inhibited by both internal and external constraints. The first is that the existing legal and policy frameworks are largely antithetical to the protection of this right. Furthermore, there is inadequate attention to a Human Rights Based Approach (RBA) to policy design and implementation with respect to this right. Poverty and inequitable gender relations inhibit the promotion and protection of the right in question, and neither is adequately addressed by the policy framework.

Against the above background, the study recommends several legislative, judicial, administrative and other measures for the enhanced protection of the right, including the following:

♦ The right to health care should be explicitly recognized and incorporated into the Bill of Rights of the Constitution.

♦ A health legislation that clearly spells out the relevant obligations and measurable benchmarks should be enacted. The legislation should expressly provide that the state is obliged to protect the right to health generally and the right to healthcare for vulnerable groups like WLA in particular. The legislation should provide for the active participation of the specific population for whom the policies are intended, such as WLA.

♦ A Rights-based Approach (RBA) should be incorporated into the design and implementation of all legislation and policies relevant to the right in question. Free ART should be provided to all WLA in need of it,

which ultimately necessitates increased funding to the health sector.

♦ Inheritance and property laws and customs should be reformed to ensure that women inherit property.

♦There should be zero tolerance of sexual and domestic violence, and this should be incorporated into the legal and policy frameworks.

♦ All necessary steps should be taken to eliminate or mitigate the stigma and discrimination against PLHA.

♦ Home based or mobile care should be encouraged.

♦ Both men and women should be targeted in any education, counseling and treatment strategies, while WLA should be provided with sustainable projects that enhance their vocational and business skills.

I. INTRODUCTION

There can be little doubt that the HIV/AIDS pandemic is one of the most challenging public health problems of the 21st century.[1] In Uganda, HIV/AIDS has claimed more than one million lives over a span of two decades since the first case was discovered in Rakai in 1982. It continues to be a major cause of death among adults.[2] Over 2,000,000 people have been infected with HIV and there are currently about 120,000-150,000 adults with the AIDS disease. Most importantly, there has also been a disproportionate impact of the pandemic on women.[3] In Sub-Saharan Africa, infection rates have been growing far more rapidly for women than they have for men, with women accounting for 57% of the infections in the region.[4] As for Uganda, the HIV prevalence rate is 5.2% and 7.3% for males and females respectively.[5]

Over the years, the Government of Uganda has implemented active HIV prevention strategies that have led to a decline in the number of infections. Because of this aggressive intervention strategy, Uganda has been hailed as a success story. However, ideologically driven abstinence and fidelity prevention programmes may have undermined this performance. There are fears that the prevalence of HIV/AIDS may in fact increase.[6] Furthermore, challenges with regard to the human rights of persons living with HIV/AIDS (PLHA) remain. There is still considerable stigma and discrimination in many areas including health care. Furthermore, there is no specific legislation devoted to HIV/AIDS-related discrimination.[7] The 1995 Constitution provides neither for the right to health nor does it bar discrimination based on health status.[8] This is despite the fact that Uganda has ratified a number of international and regional human rights instruments that obligate it to respect, protect, promote and fulfill the right to health.[9] These instruments stress the right of access to health care services including medical treatment as an essential component of the right to health.

It should be noted that for PLHA, access to antiretroviral (ARV) drugs as well as

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[1] UNAIDS 2004.

[2] See: 'Joint UN Programme on HIV/AIDS in Uganda' available at http://www.unaids.org/en/geographical+area/by+country/Uganda.asp, accessed June 20, 2006.

[3] *Id.* See also, the *Health Sector Strategic Plan*, 2005/6-2009/10, pp.37-38.

[4] UNDP 2006 at 266.

[5] AIC 2006.

[6] Uganda implemented the **A**bstinence, **B**e Faithful and Use a **C**ondom (ABC) Prevention approach which is credited to have alleviated the spread of HIV. However, at the insistence of the United States government, funding has been diverted to the A-B strategy. See, Human Rights Watch, 'A Tale of Two Presidential Initiatives, Changes in an HIV Prevention Program in Uganda', available at http://www.hrw.org/English/docs/2006/02/01/uganda12591_txt.htm, accessed June 21, 2006. See also, 'Ugandans Resist Anti-Condom Agenda', available at http: hrw.org/English/docs/2005/09/14/uganda1174.htm, accessed June 19, 2006. See also' Uganda's HIV success questioned' *BBC News*, 21 September 2004.

[7] Twinomugisha, 2004-2005 at 26.

[8] *Id.*

[9] For example Uganda ratified the Women's Convention on 22 July 1985; acceded to the ICESCR on 21 January 1987; ratified the CRC on 17 August 1990; acceded to ICCPR on 21 June1995.

to medicines for the treatment of opportunistic infections is critical to the enjoyment of their rights to life and to health. However, by 2005, only slightly over 50% of the people in need of the drugs were accessing them.[10] Even though the cost of ARV treatment has decreased in recent years, given the poverty levels in Uganda,[11] the price of treatment is still unaffordable for most Ugandans. It is estimated that over 100,000 people are in need of ARV treatment in the country.[12] This is particularly so for women, who due to their poverty and other variables such as inequitable gender relations, may not access critical health care including testing, counseling and treatment. And yet—as the UNDP has recently observed—the feminization of HIV/AIDS and the consequences of gender equity have been less visible in the main discourses on the problem.[13]

In light of the foregoing background this study examines the extent to which the legal and policy frameworks protect the right of WLA to access Antiretroviral Treatment (ART) in Uganda. The study extends the focus beyond the state's role in the protection of the right, and also considers the extent to which non-state actors—especially the institutions of globalization, such as the World Bank, International Monetary Fund (IMF) and the World Trade Organization (WTO)—impact on the policy framework in which the right in question is protected.

1.1. Working definitions

1.1.1 The Right to Health Care

The right to health care is a core aspect of the broader concept of the right to health, which entails the enjoyment of the highest attainable standard of physical and mental health.[14] The World Health Organization (WHO) recognizes this right as important for a person's health and well being.[15]Various international and regional human rights instruments to which Uganda is a party recognize the right to health care. States parties to these instruments have a minimum core obligation to ensure access to health care for vulnerable persons such as WLA.[16] The International Covenant on Economic, Social & Cultural Rights (ICESCR) has made it clear that the right of access to health goods and services especially for vulnerable or marginalized groups is non-derogable.[17] The HIV/AIDS International Human Rights Guidelines also urge states to ensure that PLHA receive safe and

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[10] See, AVERT.ORG,'Why is Uganda Interesting?' Available at http://www.avert.org/aidsuganda.htm, accessed June 20, 2006.

[11] Current poverty levels are estimated to be over 38%. See, MFPED 2005/6. See also, the MFPED, 2004/5-2007/8.

[12] *Id.*

[13] *Id.*

[14] See Articles 12 of the ICESCR and 16 of the ACHPR.

[15] WHO 1946.

[16] See, General Comment No. 3 of 1990, UN. Doc.E/1991/23, Annex III, UN ESCOR, Supp. No.3. See also: *Limburg Principles* (1987) *HUM. RTS* 9.

[17] Para. 47 General Comment 14, 'The Right to the Highest Attainable Standard of Health', Twenty Second Session, 25 April-12 May 2000, Geneva, EC. 12/2000/4.

effective medication at an affordable price.[18] In this study, the right to health care shall be taken to mean the right of WLA to access Antiretroviral Treatment (ART), which includes voluntary testing and counseling (VCT), antiretroviral drugs (ARVs) and treatment for opportunistic infections.

1.1.2 Gender and Gender Relations

The concept of gender refers to the distinctive qualities of women and men that are culturally, socially and economically determined. For the purposes of this study, gender relations shall be taken to refer to the relations between men and women that are socially, economically, politically and culturally constructed. The main interest of the study shall be the extent to which such relations affect women's access to ART.

1.1.3 Poverty

Poverty is not expressly defined in the human rights treaties. However, poverty is a multi-dimensional problem that covers the lack of material resources deemed necessary for an acceptable standard of living, and also a denial of qualitative aspects such as lack of dignity, self-respect, freedom or access to power. The Committee on Economic, Social & Cultural Rights (CESCR) has defined poverty as a 'human condition characterized by sustained or chronic deprivation of the resources, capabilities, choices, security and power necessary for the enjoyment of an adequate standard of living and other civil, cultural, economic, political and social rights'.[19] Most of these variables have an impact on the capacity of WLA to access and utilize ART. However, for the purposes of this study, poverty is viewed as the inability of WLA to access and utilize ART due to insufficient income.

1.1.4 Globalization

The concept of globalization has been defined by a number of commentators. According to Upendra Baxi,[20] globalization connotes the diminishing of the capacity of the state as the planner of national socio-economic development. It is important to underscore the point that globalization has both positive and negative consequences.[21] This has led some commentators to theorize about globalization from below and globalization from above.[22] The former has led to the liberation of oppressed individuals and communities whose plight is brought to the fore through for example Internet usage and networking. Some women have benefited from the globalization process through access to better employment opportunities and participation in decision making. NGOs have been able to network with local women's groups to make better advocacy for women's human rights. On

[18] *International Guidelines on HIV/AIDS and Human Rights*, U.N.C.H.R. res. 1997/33, U.N.Doc.E/CN.4/1997/150 (1997).
[19] WHO 2005.
[20] Baxi 2002.
[21] Oloka-Onyango 2005.
[22] See for example Aziz 1995. Oloka-Onyango, *Id.*, note 21.

the other hand, globalization from above is associated with pressure from the North on the South to adopt neo-liberal policies, including the liberalization of domestic economies, with an emphasis on the free market as the guiding parameter in the production and delivery of goods and services.[23] The major institutions of globalization, namely, the World Bank, the IMF, and the World Trade Organization (WTO) largely spearhead globalization from above.

This study is partly concerned with the extent to which globalization from above impacts on the policy framework within which the right under inquiry is protected. For those purposes, globalization refers to that process whereby the capacity of the state in the protection of the right to health care of WLA is weakened by exalting market forces in the quest to solve social and economic questions. It refers to that process where the poor are marginalized further and excluded from the development process.

1.2 Statement of the Problem and Justification

In Uganda, whereas some of the economic, social and cultural rights are expressly stated in the 1995 Constitution, the right to health care is conspicuously absent except for muted provisions in the National Objectives and Directive Principles of State Policy.[24] Although Uganda has ratified a number of human rights treaties that provide for the right to health, very few attempts have been made to map out the parameters of the right to health care within the domestic context. Given that there are no local judicial decisions on the right under inquiry except for those involving medical negligence and malpractice, it is not clear what kinds of redress are available in case of violation of the right under investigation. Consequently, the study fills this gap by delimiting the nature, scope and content of the right and the attendant obligations and possible remedies in the event that the right is violated.

It should however be noted that law-based strategies are only some of the means in the struggle for the protection of the right to health care of WLA. Thus, it is important to view law within the policy framework that has a bearing on the protection of the right. The state has designed a number of policies and strategies to tackle the HIV/AIDS pandemic.[25] Considerable research has also been carried out on the subject. However, very little of the research analyzes the policy framework from gender and human rights perspectives. And yet, it is now recognized that the protection of women's human rights (including their right to health care) is critical for any meaningful response to HIV/AIDS.[26] Consequently, it is necessary to find out the extent to which the relevant state policies and strategies protect or negate the right to health care of WLA. To what extent do

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[23] *Id.*

[24] See for example Objective XX (on medical services). This makes the right appear as if it is simply an aspiration and not an entitlement.

[25] See for example, Ministry of Health, 2003a; and 2003b.

[26] See for example, UNAIDS, 'HIV/AIDS, Human Rights and Law' available at http://www.unaids.org/en/in+focus/hiv_aids_human-rights.asp, accessed July 30, 2006.

the policies and strategies promote availability and access to ART? Do they take into account the interconnectedness between civil and political rights (such as the right to life, and participation) on the one hand and economic, social and cultural rights on the other? Is the problem of availability and access to ART viewed as an entitlement giving rise to legal obligations or simply as a social or resource problem? In other words, does the policy framework create obligations on the state to respect, protect and fulfill the right to health generally and the right of WLA to heath care in particular? To what extent does the policy framework take into account the impact of international factors such as globalization? These and other related issues call for a critical examination of the policy framework from gender and human rights perspectives.

Against the above background, it is important to underscore the point that both women and men may be infected and affected by HIV/AIDS. HIV/AIDS impacts on the enjoyment of the right to health care of both women and men. The question therefore is: why focus on WLA? This study offers several reasons. In the first instance, it is now well known that women are more socially, culturally and biologically vulnerable because of their HIV status.[27] Women may be more susceptible than men to infection from HIV in any given heterosexual encounter due to biological factors.[28] Increasingly, the face of HIV/AIDS is a woman's face, in both a positive and a negative sense. It should be noted that the feminization of HIV/AIDS is closely intertwined with poverty. Women bear a disproportionate part of economic recession and impoverishment since they assume responsibility for family survival strategies by working longer hours inside and outside the home, caring for the sick and raising children.[29] Studies have also found that because of their different positioning in society, economic factors may impact on men and women differently.[30] It has also been pointed out that women tend to suffer illness in silence in order not to disrupt household organization.[31] Women are thus likely to have more problems of physical and economic access to ART than men.

The study focuses on women because of their unique role in society and because women and men's lives are experienced differently. The study recognizes the fact that efforts to end the increasing feminization of HIV/AIDS cannot be only through access to treatment. Consequently, it is necessary to confront those societal beliefs and practices that inhibit WLA from realizing their right to health care. By analyzing the extent to which the right to health care of WLA is protected, a number of outputs will be attained. First, a contribution will be made to the understanding of the nature, scope and content of the right under investigation. Secondly, the responsibility of the state and other actors towards protection of

[27] UNAIDS, *op.cit.* at 6. See also, WHO, *Integrating Gender into HIV/AIDS Programmes: A Review Paper,* 2003.
[28] *Id.* PEAP at 178 notes that women are physically more vulnerable in terms of maternal health and HIV/AIDS.
[29] *Id.*
[30] See Stamp 1989.
[31] *Id.*

the right will be clearly demarcated. Thirdly, the study will promote a greater awareness among health professionals, lawyers, and judicial officers about the critical link between gender, health and human rights generally and the contribution of the right to health care to the alleviation of the problem of availability and access to ART for women in particular. Finally, the information presented and the strategies advanced can be used in policy design, implementation and decision-making.

1.3 Objectives and Research Questions

The broad objective of the study is to analyze the factors that affect the protection of the right to health care of WLA through a survey of the juridical/legal, social and policy contexts with a view of contributing to the formulation of appropriate modalities and recommendations for the enhanced protection of the right.

The specific objectives are:

a) To examine the legal status of the right within the international, regional and domestic contexts.
b) To determine the obligations of the state and other major actors that impact on protection of the right.
c) To determine the major constraints to protection of the right.
d) To explore and recommend modalities and approaches for the enhanced protection of the right.

The study attempted to answer the following questions:

a) What is the legal status of the right to health care of WLA in Uganda?
b) What are the obligations of the state and other major actors involved in protection of the right?
c) What are the major constraints to protection of the right?
d) How best can the right be protected?

1.4 A Note on Methodology

1.4.1 Study Population and Scope

The population that was the subject of research focus comprised of all the women receiving ART at Mbarara Hospital in Mbarara District, Western Uganda and key informants knowledgeable on the subject. The hospital was chosen because it is both a referral facility for the region as well as a teaching hospital for Mbarara University of Science and Technology (MUST). It also has a collaborative arrangement with the Joint Clinical Research Centre (JCRC). The Aids Support Organization (TASO) branch is also within the vicinity of the hospital. The majority of respondents had a rural-urban mix. The study focuses on the right of women to access ART in Uganda. It examines the right under inquiry within the spectrum

of international and regional human rights instruments, and locates it within the domestic context. The study analyzes relevant national legislation, policies and jurisprudence (including that from other jurisdictions) that have a bearing on the right. The study reviews the major constraints to protection of the right in light of the benchmarks laid out in the legal and policy framework. Finally, the study draws conclusions, explores and recommends modalities and approaches for the enhanced protection of the right.

1.4.2 Methods and Sampling

Qualitative techniques of library research and desktop literature review, observation, and in-depth interviews were the more prevalent methods of conducting the research. Qualitative methods help the researcher to understand people as they interacted in various social contexts and to define social reality from their own experience and perspective.[32] Qualitative methods allowed for contextuality and continuity, all of which were crucial for the research questions raised.[33] The study was primarily library and desk based. Information gathered from the library and the Internet enabled the framing of the questions that were later used during interviews with the respondents. The purpose of the interviews was largely to solicit information about the major constraints to the protection of the right in the context of the existing legal and policy framework. A number of key informants were interviewed: 2 from the Ministry of Health, 2 health professionals, and 1 from AGHA-Uganda. Selection was based on their experience and knowledge of the issues and concerns of the study. Furthermore, I interviewed 10 pregnant women, 6 widows, and 15 married but not pregnant women receiving ART at Mbarara Hospital. In selecting the women, I ensured that there was a rural-urban mix among them. All the respondents were selected through purposive sampling.[34] Permission to carry out the research was obtained from Uganda National Council of Science and Technology. The respondents were informed of the purpose of the research, and informed consent was obtained from them. The names of the respondents are concealed for confidentiality.

1.5 A Summary of the Relevant Literature

1.5.1 HIV/AIDS and the Right to Health Care

There is abundant literature on HIV/AIDS from public health, medical and sociological points of view. This literature examines Uganda's prevention strategies, attitudes and perceptions towards PLHA, the impact of the pandemic on various age groups, and the general socio-economic consequences of HIV/AIDS.[35] However, there is a dearth of literature on economic, social and cultural

[32] This sampling technique enables the researcher to deliberately select respondents whose life situations and experiences reflect the themes of the study. See Sarantakos 1998.
[33] *Id.*
[34] *Id.*
[35] See for example, Obbo 1995; Pool *et al* 2000;Gysels 2001; Tamale 2004.

rights in general and the right to health care in particular. The few pieces of literature correctly discuss the right to health care within the realm of economic, social and cultural rights.[36] Some commentators argue that economic, social and cultural rights such as the right to health care are not rights because they are programmatic, costly and are generally not justiciable.[37] Byamukama shares this view and contends that in a resource starved country like Uganda, the right to health should not be recognized as a right.[38] Wandira also argues that the right to essential treatment is not justiciable and the international instruments containing the right to health though binding on Uganda are not enforceable. [39]

However, there is an emerging consensus that health rights are indeed justiciable and enforceable.[40] In her discussion of the right to health under the ACHPR, Kiapi argues that the right to health, like any other right can be invoked and enforced in courts of law.[41] In a generalized manner, Nakadama examines prisoners' right to health in Uganda and provides some recommendations regarding the treatment of inmates with HIV/AIDS.[42] Muganda looks at the right to medical care and deals superficially with HIV/AIDS among other contagious diseases in Uganda.[43] Muwanguzi adopts a much broader approach and looks at all the human rights affected by HIV/AIDS and provides an overview of judicial activism with regard to the human rights affected.[44] Tuhaise brings out the link between gender and HIV/AIDS and surveys the human rights of WLA but without particular attention to the right to health care.[45]

In a study of selected districts in Uganda, the Health Rights Action Group (HRAG) outlines the main obstacles to the realization of some of the rights of PLWA and finds that most of these rights are seriously violated.[46] Kyomuhendo analyses the situation of children and other vulnerable groups in Uganda with regard to infringement of their rights as a result of HIV/AIDS.[47] None of this literature delimits in considerable detail the nature, scope and content of the right of access to ART. The literature also does not clearly spell out the obligations of the state and non-state actors towards protection of the right. By critically

[36] See for example, Oloka-Onyango 2004; M. Ssenyonjo 2003.
[37] See for example,Vierdag 1978.
[38] Byamukama, 2000.
[39] Wandira 2005
[40] See for example, An-Na'im 2004.
[41] Kiapi 2005.
[42] Nakadama 2001.
[43] Muganda 2002.
[44] Muwanguzi 2002.
[45] Tuhaise 1998.
[46] HRAG 2004.
[47] Kyomuhendo 2004.

appraising the legal and policy framework within which women's right to ART is protected in Uganda, it is hoped that the study will contribute to the clarification of the scope and contours of the right and the attendant obligations to protect the same.

1.5.2 Constraints to Protection of the Right to Health Care

1.5.2.1 Poverty

There is plenty of literature that links poverty to women's and men's vulnerability and inability to access social services such as health care. In a study of health care seeking and financing by households in Kabale and Iganga districts in Uganda, Lucas and Nuwagaba found that the poor have at times to borrow money to pay for health care.[48] I also found that rural poor women in Kashambya Sub-county, Kabale District do not access and utilize maternal health care partly due to the inability to pay for the same.[49] The PEAP also identifies poverty as one of the factors that inhibit vulnerable members of the household from accessing HIV/ AIDS treatment and that the latter competes with other crucial expenditures such as food, shelter and educational expenses.[50] The PEAP also correctly notes that the majority of ARV treatment has been limited to private self-paying patients, a factor that ignores the social costs of the epidemic.[51]

It should be noted that some of the literature views poverty simply as a matter of impoverishment. However, poverty is a multidimensional problem that goes beyond the traditional income approach or the failure to meet basic needs such as health care and is linked to disempowerment, dependency and oppression.[52] This is true both in respect of the individual's ability to access health care such as ART and the state's capacity to provide for the same. Human rights law places the primary responsibility to protect the right to health care on the state. But the available literature shows that globalization from above weakens the state's capacity to do so.[53] It is thus necessary to analyze the root causes of poverty by interrogating the role of globalization in the struggle to realize economic, social and cultural rights such as the right to health care.

[48] Lucas & Nuwagaba 1999.
[49] Twinomugisha 2004.
[50] PEAP, *op cit* at 149.
[51] *Id.*
[52] *Id.*
[53] See for example, Baxi 2002.

1.5.2.2 Gender Relations

There is abundant literature explaining gender disparities existing in Uganda and how women have been short-changed and by-passed by the development process.[54] Various commentators decry the limited or low participation of women in decision-making processes.[55] There is also an increased recognition that women's utilization and access to health care can only be effective when the underlying gender relations such as the sexual division of labour, and the access to and control of resources are addressed.[56] It is also recognized that gender plays an integral role in determining an individual's vulnerability to infection, his or her ability to access care, support or treatment, and the ability to cope when infected or affected with HIV/AIDS.[57] The literature also stresses that for the effectiveness of interventions designed to reduce risk or vulnerability or to alleviate the impact of HIV/AIDS to be enhanced, gender differences and gender-specific concerns must be acknowledged and addressed directly.[58]

Although on balance the literature is conclusive in the direction of the impact of inequitable gender relations on women, it does not consider how gender affects other sources of power. In developing countries like Uganda, class variables intersect with gender to compound the complexity of power relations.[59] In order to appreciate the actual impact of gender relations on access to health care, it is critical to take into account the fact that the forces of globalization increasingly determine the internal domestic structure of such countries.[60] The literature also views men as villains yet there is evidence to show that blaming men for perpetuating all injustices against women is not a productive way to tackle the unequal balance of power in gender relations.[61] Men and women are certainly important in matters of sexual and reproductive health. There is also a tendency for the literature to treat women as a homogeneous category, yet as Kabeer[62] has observed, gender relations may be experienced and expressed in different ways, places and time. Through an empirical probing of the issues and concerns at stake, I examine the impact of gender relations on women's right of access to ART bearing in mind other crucial variables such as class.

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[54] See for example Kasente 2000; Matembe 2002; Tamale 1999.
[55] *Id.*
[56] See, Sali 2003.
[57] See for example, Berkley, *et al* 1990; Kisekka, 1990; Mayambala 1999; Rwabukali 1997.
[58] *Id.*
[59] On this view see, Odim 1991.
[60] See,Hills 1994.
[61] See Twinomugisha, *op.cit.*, note 49.

II. THE LEGAL STATUS OF THE RIGHT TO HEALTH CARE OF WLA IN UGANDA

One of the main tasks of this study is to determine the legal status of the right to health care of WLA. Through an examination of international and regional human rights instruments and the 1995 Constitution, I illustrate the point that WLA have a right to health care, which includes access to ART. Though neglected in the past as being vague, costly, and difficult to enforce,[63] there is some evidence that the right to health is beginning to attract more attention at the international level and in some national jurisdictions. Health is increasingly being considered as a human rights issue. However, in Uganda, there have been few attempts by scholars and researchers to consider the scope of the right to health care and its attendant obligations. Like other economic, social and cultural rights, the right to health care has received scant attention especially when contrasted to the amount of time and energy devoted to civil and political rights. Given that the 1995 Constitution does not expressly provide for the right under inquiry, it is necessary to utilize international and regional human rights standards against which relevant national laws and policies may be measured. Consequently, in this section of the paper, I present a synoptic review of these instruments by way of fortifying the argument of the existence of the right in the domestic context.

2.1. The International and Regional Context

2.1.1 WHO Constitution and the UDHR

Within the UN texts, the first reference to the right to health is contained in the Constitution of the WHO whose preamble provides,

> *The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.*[64]

According to the UDHR,

> *Everyone has a right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.*[65]

Both the WHO Constitution and the UDHR treat health as a fundamental human right. However, health is expressed in the context of many other rights. Because of subsequent intensive state practice, it can be argued that the UDHR is part of

[62] Kabeer 1991.
[63] See for example, Vierdag, *op.cit.*, note 37.
[64] WHO 1946.
[65] Article 25 of the UDHR.

customary international law with direct application to states, including Uganda.[66]

2.1.2 The ICESCR

The ICESCR provides for 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.'[67] It lays down the steps to be taken by states towards the realization of this right which include those measures necessary for the reduction of the still birth rate and of infant mortality and for the healthy development of the child;[68] the prevention, treatment and control of epidemic, endemic, occupational and other diseases;[69] the creation of conditions which would assure to all medical service in the event of sickness.[70] Although Article 12 of the ICESCR sets an ambitious policy goal, it at least attempts to develop the form and content of the right to health. The Covenant improved upon the somewhat amorphous provision of the UDHR.

The CESCR has elaborated on the right to health.[71] The right to health includes certain components, which are legally enforceable.[72] The CESCR has outlined certain interrelated and essential elements for the realization of the right. First, health care facilities, goods and services should be available in sufficient quantity within the state party[73] and must be physically and economically accessible to all, especially the most vulnerable or marginalized sections of the population such as PLHA.[74] Accessibility also includes the right to seek, receive and impart information and ideas concerning health issues.[75] Secondly, the health facilities, goods and services must be affordable for all, including socially disadvantaged groups.[76] Thirdly, health facilities, goods and services must be respectful of medical ethics, culturally, scientifically and medically appropriate.[77] The CESCR has stressed the right to participation in political decisions relating to the right to health taken at community and national levels.[78] According to the CESCR, the realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health.[79] The CESCR enjoins states to integrate a gender perspective into their health related policies, planning, programmes and research in order to promote better health for women and men.[80]

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[66] See, Kinney 2001.
[67] Article 12(1) of the ICESCR.
[68] Article 12(2) (a) of the ICESCR.
[69] Article 12(2) (c) of the ICESR.
[70] Article 12(2) (d) of the ICESR.
[71] CESCR, General Comment No.14, note 17.
[72] Para.1, General Comment 14.
[73] Para.12(a) of General Comment 14.
[74] Para.12(b) of General Comment 14.
[75] *Id*.
[76] *Id*.
[77] Para. 12(c) of General Comment 14.
[78] Para. 17 of General Comment 14.
[79] Para. 21 of General Comment 14.
[80] Para. 20 of General Comment 14.

2.1.3 Convention on the Rights of the Child (CRC)

The CRC guarantees the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.[81] States are also called upon to ensure that children are not deprived of their right to health care services.[82] States parties are enjoined to pursue full implementation of the right and to take all appropriate measures to *inter alia,* ensure the provision of necessary medical assistance and health care to all children with an emphasis on the development of primary health care.[83] The states parties should also ensure appropriate pre-natal and post-natal care for mothers.

2.1.4 Convention on the Elimination of all Forms of Discrimination against Women (CEDAW)

CEDAW obliges states parties to take all appropriate measures to ensure that women are guaranteed access to health care.[84] States are enjoined to ensure that women in rural areas enjoy the right to have access to health care facilities, including information, counseling and services.[85] CEDAW requires the provision of appropriate services in connection with pregnancy, confinement and the postnatal period, granting free services where necessary.[86] It can be argued that for pregnant women, this provision protects their right to anti-retroviral treatment in their individual capacity.

2.1.5 The African Charter on Human and Peoples Rights (ACHPR)

The ACHPR guarantees every individual the right to enjoy the best attainable state of physical and mental health.[87] States are obliged to take the necessary steps to protect the health of their people and to ensure that they receive medical attention when they are sick.[88] States parties are also obliged to ensure the elimination of discrimination against women as stipulated in international declarations and conventions.[89] It can be argued that this provision renders international standards concerning women's human rights directly applicable to states parties without need for any further incorporation. Of particular note isthe fact that the Protocol to the ACHPR[90] enjoins states parties to ensure that

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[81] Article 24 of CRC.
[82] *Id.*
[83] *Id.*
[84] Article 2 (e).
[85] Article 14.
[86] Article 12 (2).
[87] Article 16 (1).
[88] Article 16 (2).
[89] Article 18 (2).
[90] Protocol to the ACHPR on the Rights of Women in Africa, adopted July 11, 2005 (herein after, 'the Protocol).

the right to health of women, including sexual and reproductive health is respected.[91] States parties are obliged to take steps to provide adequate, affordable and accessible health services.[92] States parties are also obliged to establish and strengthen existing pre-natal, delivery and post-natal services, during pregnancy and while breastfeeding.[93] It should also be noted that in addition to the African Commission on Human and Peoples Rights (the African Commission), complaints in respect of violations of the ACPHR can now be referred to the African Court.[94]

2.2. Nature of Obligations

2.2.1 Obligations of the State

The state has obligations to respect, protect and fulfill the right to health. Audrey Chapman suggests that the obligation to respect includes both the duty not to violate and the duty to uphold or implement, and extends to the duty to respect the equality of all persons and a responsibility not to discriminate.[95] Chapman is also of the view that the obligation requires the state to remove obstacles or barriers to access, a kind of affirmative action applied to the health sector.[96] According to the CESCR, the obligation to respect includes the obligation to refrain from marketing unsafe drugs and from applying coercive medical treatments.[97] States should refrain from interfering directly or indirectly with the enjoyment of the right to health.[98]

The obligation to protect requires the state to take measures that prevent third parties from interfering with the right to health.[99] The state is particularly obliged to act against the negative effects of globalization.[100] The state should adopt legislation or take measures ensuring equal access to health care and health related services provided by third parties.[101] States should also ensure that the privatization of the health sector does not constitute a threat to the availability, accessibility and quality of health facilities, goods and services.[102] The obligation to protect also requires the state to control the marketing of

[91] Article 16 of the Protocol.
[92] Article 14.
[93] *Id.*
[94] The African Court on Human and Peoples' rights was recently constituted. It has 11 judges elected on January 22, 2006 at the Eighth Ordinary Session of the Executive Council of the African Union . The Court had its first meeting on July 2-5, 2006. Details are available at http://en.wikipedia.org/wiki/African_Court_on_Human_and_Peoples'_Rights, accessed on December 18, 2006.
[95] Chapman 1993. See also, Ngwena & Cook 2005.
[96] Chapman, *op cit.* at 50.
[97] Para. 24 General Comment 14.
[98] *Id.*.
[99] Para.33, General Comment 14.
[100] Article 19 (f) African Women's Protocol.
[101] Para. 35 General Comment 14.
[102] *Id.*

medical equipment and medicines by third parties.[103] States parties are obliged to take measures to protect all vulnerable and marginalized groups of society such as women and children in light of gender-based expressions of violence.[104]

The obligation to fulfill requires states parties to give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation.[105] States parties are obliged to facilitate, that is, to assist individuals and communities to enjoy the right to health.[106] They are also obliged to provide a specific right such as health care when individuals or a group are unable—for reasons beyond their control—to realize that right by means available at their disposal.[107] As with other economic, social and cultural rights, the right to health should be progressively realized to the maximum level of available resources.[108] However, the notion of progressive realization should not be interpreted as depriving states parties' obligations of meaningful content.[109] States parties have 'a specific and continuing obligation to move as expeditiously and effectively as possible' towards the full realization of the right to health.[110] Retrogressive measures are not permissible except where the state justifies them.[111] The state has two immediate obligations: to ensure that the right to health will be exercised without discrimination of any kind; and to take deliberate, concrete steps towards the realization of the right to health.[112]

The jurisprudence in this area has developed the concept of minimum core content. States have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights in the ICESCR, including essential primary health care.[113] The state party must demonstrate that it has used all resources that are at its disposition in an effort to satisfy the minimum obligations.[114] The CESCR has stated that these obligations include: a) to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable and marginalized groups; b) to ensure access to minimum essential food which is nutritionally adequate and safe; c) to provide essential drugs from time to time, and, d) to adopt a national public health strategy and plan of action.[115] The latter should be periodically reviewed on thebasis of a participatory and transparent process guided by verifiable indicators and benchmarks.[116] The CESCR is of the view that a state party cannot under any

[103] *Id.*
[104] *Id.*
[105] Para.36 General Comment 14.
[106] Para. 37 General Comment 14.
[107] *Id.*
[108] Article 2 of the ICESCR. See also Para. 30 General Comment No. 14.
[109] Para.31 General Comment 14.
[110] *Id.*
[111] Para. 32 General Comment 14.
[112] Article 2(1) of the ICESCR. See also, Para. 30 General Comment No. 14.
[113] Para. 43 General Comment 14.
[114] *Id.*
[115] *Id.*
[116] *Id.*

circumstances, justify its non-compliance with the core obligations, which are non-derogable.[117]

It should be noted that the CESCR had earlier developed guidelines on reporting that enumerated a number of indicators that could assist in understanding the concept of minimum core content. The indicators include: 1) government health expenditure as a percentage of Gross National Product (GNP); 2) expenditure on health care as a percentage of general government expenditure; 3) proportion of the population having access to trained personnel and to 20 essential drugs; 4) proportion of pregnant women having access to trained personnel during pregnancy and delivery; 4) proportion of infants having access to trained personnel for care, and 5) life expectancy.[118] It can be seen that for WLA, the core obligations rotate around non-discrimination, the right to life and human dignity. These can be realized through enhanced availability and access to ART. Even in times of severe resource constraints, vulnerable members of society, such as WLA should be protected. These issues are also emphasized in U.N. consensus documents. For example, the U.N. Guidelines on HIV/AIDS and Human Rights stress access to HIV/AIDS related treatment.[119]

2.2.2 Obligations of Non-state Actors

2.2.2.1 The Institutions of Globalization

It is a trite principle of international human rights that the primary responsibility to respect, protect and fulfill human rights lies with the state. However, the globalization process has weakened the capacity of the state to provide social services, such as health care to the people. Institutions such as the World Bank, IMF, and WTO are increasingly determining and influencing the policy framework in the country. Their activities have a direct impact on the ability of the state to provide for the general welfare of the population. For instance, the World Bank is the largest source of funding for development programmes and compliance with IMF conditionality is usually a pre-requisite to other sources of funding.[120] The activities of these institutions make policies less transparent, and accountable to traditional democratic practices. Therefore, what are their obligations in human rights terms?

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[117] Para. 47 General Comment 14.

[118] See,CESCR, Guidelines on Reporting, Questions Relating to Article 12 of the ICESR. Report of the Economic, Social and Cultural Rights, UN doc. E/1991/23, pp.88-110.

[119] UN. Guidelines on HIV/AIDS.

[120] See for example, Ranis 1997.

According to the CESCR, international organizations should co-operate effectively with states in relation to the implementation of the right to health at the national level in respect to their individual mandates.[121] The World Bank and the IMF are particularly enjoined to pay greater attention to the protection of the right to health in their lending policies, credit agreements and structural adjustment programmes.[122] These institutions are called upon to adopt a human rights approach in their policies and programmes.[123] At the same time, it is important to recall that while the World Bank and the IMF concede their impact on human rights, they have refused to hold themselves accountable to human rights standards. They argue that their mandate, which is contained in their constitutive documents, is limited to economic matters but not human rights concerns, which are essentially political.[124]

It is true that due to external pressure, especially from civil society organizations, the World Bank and the IMF are increasingly paying attention to poverty alleviation issues. The World Bank accepts that sustainable development is impossible without human rights.[125] However, the language used is not framed in terms of human rights obligations. The World Bank insists that human rights should not be addressed outside the charter establishing the organization.[126] Furthermore, the major aim is financial stability not the welfare of the population as such. For example, the World Bank President stated,

> *We must address the issues of long-term equitable growth on which prosperity and human progress depend.....We must focus on social issues...if we do not have greater equity and social justice, there will be no political stability and without political stability no amount of money put together in financial packages will give us financial stability.*[127]

It should also be noted that the U.N. Charter defines the purpose and the objectives of the U.N. as including the promotion of higher standards of living and the respect and general observation of human rights.[128] As international organizations, the World Bank, IMF and the WTO, like any other multilateral organizations are the subjects of international law and are therefore bound by the provisions of the U.N Charter. Such organizations are responsible for not violating customary international human rights law as contained in U.N resolutions and declarations.[129] These institutions should not therefore hide behind their constitutive documents so as not to respect human rights. They have a continuing

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[121] Para. 64 General Comment 14.
[122] *Id.*
[123] *Id.*
[124] See, Article V, Sec. 10 of the Articles of Agreement.
[125] World Bank 1998.
[126] *Id.*
[127] Remarks at Global Lenders' Talks, *N. Y. Times,* 7 Oct. 1998, available at http;//www.nytimes.com/library/world/gtext.html, accessed May 20, 2006.
[128] See, Preamble, Articles 55 and 56 of the Charter of the United Nations.
[129] On international organizations as holders of obligations in international human rights law, see, Oloka-Onyango, & Udagama 2000.

obligation to ensure that they do not impose policies on the country in disregard of benchmarks established in human rights instruments. In fact, organizations like the WTO have an explicit obligation to protect public health, which would include the obligation to ensure that their policies do not act as a barrier to the realization of aspects of the right to health such as access to ART.[130]

It is important to point out that the aforesaid international institutions are created by member states. Consequently, states parties, especially those of the North have an obligation to ensure that their actions as members of international organizations take due account of the right to health.[131] States parties who are members of the World Bank and the IMF should pay greater attention to the protection of the right to health in influencing lending policies, credit agreements and other measures undertaken by these institutions.[132] I now turn to the obligations of private individuals.

2.2.2.2 Obligations of Other Actors

It should be noted that a number of violations of women's human rights generally and of the right to health care of WLA in particular occur within the so-called private sphere, especially within the family, and the market place. As pointed out above, the state has an obligation to regulate the activities of third parties in order to ensure that they do not violate the rights of its people. CEDAW clearly stipulates that states parties should take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise.[133] But do individuals have obligations to protect the right to health care? To what extent can they be held accountable for violations of the right?

In general, treaties do not create direct obligations for private individuals, unless it was the intention of the parties to do so. However, individuals have long been held to be directly criminally responsible for crimes against humanity and for war crimes.[134] Under national law, individuals are responsible for the commission of crimes within national jurisdictions. In international law, it is not so clear whether an individual can be held responsible for denying a person access to health care. The 1995 Constitution imposes obligations on private individuals to respect human rights. It provides that it is the duty of every citizen of Uganda to respect the rights and freedoms of others[135] and to protect vulnerable persons against any form of abuse, harassment or ill treatment.[136] The Constitution further provides as follows,

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[130] See,Abbot 2005..
[131] Para. 39 General Comment 14.
[132] *Id.*
[133] Article 2 (e).
[134] Brownlie 1979.
[135] Article 17 (1) (b).
[136] Article 17 (1) (c).

> *The rights and freedoms of the individual and groups enshrined in this chapter [Four] shall be respected, upheld and promoted by all organs and agencies of Government and by all persons (emphasis mine)*[137].

The word 'persons' includes natural and artificial persons. It can thus be argued that this constitutional provision moves accountability beyond the traditional focus on the state as sole protector of human rights. Private persons—whether in the family, community, government or the market—can be held accountable for the violation of human rights, such as the right to health care. Consequently, private individuals like husbands who deny women access to health care by threatening or committing domestic violence can be held accountable for violations of the right to health care of WLA, and freedom from torture or cruel, inhuman or degrading treatment.[138] NGOs, private health facilities and their health workers can also be held accountable. The next section attempts to locate the right in question within the domestic Ugandan context through an analysis of various constitutional provisions.

2.3 The Domestic Context

Unlike earlier constitutions that were silent on economic, social and cultural rights, the 1995 Constitution covers some of these rights. For example, it provides for the right to education,[139] the right to a clean and healthy environment,[140] women's rights,[141] and minority rights.[142] However, the Constitution does not expressly provide for the right to health care. Because of this, some may argue that the right to health care is not justiciable in Uganda. Iain Byrne has correctly observed that non-cofidification of the right to health in domestic law is not necessarily a bar to its adjudication and enforcement by the courts.[143] Byrne points out that the lack of constitutional protection for health rights provides courts, lawyers and activists with significant but not insurmountable challenges for enforcement.[144]

It should be noted that the Constitution contains various provisions, which an activist court can apply to protect the right to health generally, and the right to health care of WLAs in particular. It adopts the position in the ACHPR and obliges the state to take practical measures to provide basic medical services such as ART to the population.[145] Some commentators argue that National Objectives are not binding on the state since they are located outside the substantive sections of the Constitution.[146] However, the Constitution is clear: objectives must guide

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[137] Article 20 (2).
[138] Article 24 of the 1995 Constitution. This freedom is non-derogable (article 44(a)).
[139] Article 30.
[140] Article 39.
[141] Article 33.
[142] Article 36.
[143] Byrne (2005) at 1.
[144] *Id.*
[145] Objective XX.
[146] See for example, UHRC 2000 at 8.

all organs and agencies of the state, including courts, in the application and interpretation of the Constitution.[147] Experiences from other jurisdictions show that a creative court can effectively apply objectives or directive principles of state policy (DPSP). For example in the Indian case of *Keshavananda Bharati v. State of Kerala*[148] the Supreme Court stated that although Article 37 of the Indian Constitution expressly provides that the DPSP are not enforceable by any court, they should enjoy the same status as traditional fundamental rights. Furthermore, the amended Constitution provides as follows:

> *Uganda shall be governed based on the principles of national interest and common good enshrined in the national objectives and directive principles of state policy.*[149]

It can be stated that the foregoing article, which exists as a substantive part of the Constitution, renders the objectives and DPSP in the Constitution justiciable. The article makes it mandatory for the state to take them into account in the governance of the country.

The Constitution guarantees the right to life. This right has been interpreted to move beyond the arbitrary taking of life or through the death penalty as envisaged in the Constitution. For example, in *Paschim Banga Khet Mazdoor Sanity and Others v. State of West Bengal and Anor*,[150] the Supreme Court of India held that denial by various government hospitals of emergency treatment for serious head injuries violated the right to life. The court concluded that the state could not abdicate its responsibility to provide such care by pleading financial constraints. The court held that the right to emergency medical care formed a core component of the right to health, which is an integral part of the right to life. In *S. v. Makwanyane & Anor*,[151] it was held that the right to life under the South African constitution is,

> *not simply to enshrine the right to existence. It is not life as a mere organic matter that the constitution cherishes, but the right to human life: the right to live as a human being, be part of the broader community, to share in the experience of humanity.*

In *Malawi Savings Bank v. Bonny Brighton Kolombola*,[152] the court noted that life must not be limited to breath alone but extend to all other activities that give breathing human dignity. For WLA to live a good quality life, they require ART, which is crucial for their survival. In *Cruz Bermudez et al v. Ministerio de Sanidad*

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[147] Objective I (1).
[148] (1973) 4 SCC 225
[149] Article 8A.
[150] (1966) AIRSC 246.
[151] (1995) 3 SA 391.
[152] Civil Cause No. 1394 of 1997.

Asistentia Social,[153] the Supreme Court of Venezuela held that the right to health and the right to life of PLHA that did not have access to ARVs were closely linked to their right to access the benefits of scientific progress. The court ordered government to provide free ARVs to all PLHA that require them. In *Salvatori Abuki v. Attorney General*,[154] the right to life was found to include a right to a livelihood.

The Constitution specifically protects women's human rights.[155] It obliges the state to protect women and their rights, taking into account their unique status and maternal functions in society.[156] The Constitution commands the state to provide the facilities necessary to enhance the welfare of women to enable them to realize their full potential and advancement.[157] It can be argued that these provisions oblige the state to protect the right to health care of WLA by ensuring that they can access ART.
The Constitution provides for other rights not specifically mentioned and enacts as follows:

> *[t]he rights, duties, declarations and guarantees relating to the fundamental and other human rights and freedoms specifically mentioned in this Chapter shall not be regarded as excluding others not specifically mentioned.*[158]

As illustrated above, the right to health care is defined in instruments to which Uganda is a party. It can thus be argued that the right to health care of WLA is covered under those rights not specifically included in the Constitution. In the next section of the paper, I consider the major constraints to protection of the right in question.

III. CONSTRAINTS TO PROTECTION OF THE RIGHT TO HEALTH CARE OF WLA

From the preceding analysis it is quite clear that legally, WLA have a right to health care, including access to ART. However, protection of the right is hampered by a number of internal and external constraints that cut across the legal and political spectrum. Some of these constraints affect the state's capacity to protect the right to health generally and the right to health care of WLA in particular. Others directly impact on the ability of WLA to access and utilize ART. Below, I present a discussion of the major constraints affecting protection of the right.

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[153] Case No. 15.789; Decision No. 91615 (1999). See also *Minister of Health v. Treatment Action Campaign* (TAC) (2002) 5 SA 721 where the Constitutional court of South Africa ordered the state to provide comprehensive antiretroviral drugs to prevent mother-to-child transmission.
[154] Constitutional Petition No. 2 of 1997. See also, *The Social and Economic Rights Action Centre and the Centre for Economic and Social Rights v. Nigeria,* Decicion Regarding Communication No. 155/96, African Comm. Hum. & Peoples' Rights, Done at the 30th Ordinary Session, held in Banjul, the Gambia from 13-27 October 2001.
[155] Article 33.
[157] Article 33 (3).
[158] Article 33 (2).

3.1 The Legal Framework: A 'Mixed Grill'

International human rights law accentuates the adoption of legislative measures as one of the major means through which rights enshrined in various human rights instruments can be realized in the domestic arena.[159] Although the CESCR recognizes that each state has a margin of discretion in assessing the apposite feasible measures for implementing the right to health, it enjoins states to consider adopting a framework law to operationalize the right.[160] Such a law should include, *inter alia,* provisions on the targets to be achieved, the time frame for their achievement, and the means by which the right to health benchmarks could be achieved.[161] In Uganda, there is no law that specifically deals with the right to health and its components like the right to health care of WLA. None of the international and regional human rights instruments that recognize the right to health have been directly incorporated into the domestic legal system. The available legislation is either outdated and outmoded or piecemeal and simply inadequate in ensuring protection of the right to health generally and the right to health care of WLA in particular. Most of the issues concerning WLA are covered under policies, which are not legally binding.

The main legislation on the protection of public health is the Public Health Act.[162] It should be noted that although the protection of public health and human rights are aimed at the advancement of human well-being, there is always a potential tension between the two.[163] Human rights can be limited on grounds of protection of the public health.[164] However, the Public Health Act adopts an approach that is antithetical to the protection of human rights especially those of PLHA. The Act provides for quarantine measures, compulsory notification and treatment.[165] A related legislation is the Venereal Diseases Act,[166] which enacts as follows,

> *Any medical officer of health may require any person who he or she knows or reasonably suspects to be infected with a venereal disease to submit himself or herself for examination at such time and places as the medical officer of health may direct.*[167]

The Act makes it mandatory for the person infected with a venereal disease to name the person who infected him or her.[168] Given that in Uganda, HIV infection is largely through heterosexual contact, the foregoing provisions may be employed

[159] See for example, Article 2(2) of the ICESCR.
[160] Para. 53 General Comment 14.
[161] *Id.*
[162] Cap. 281, Laws of Uganda.
[163] See, J. Mann *et al* (1999).
[164] Article 43 of the 1995 Constitution provides for general limitation of human rights. One of the grounds of limitation is public interest, which includes protection of the public health.
[165] See for example, Parts III-VIII of the Act.
[166] Cap. 284, Laws of Uganda.
[167] Sec. 2.
[168] Sec. 4 (1).

by an overzealous medical officer against PLHA in utter violation of their right to privacy and human dignity.

Other pieces of legislation that have a bearing on protection of the right under inquiry deal with drugs and the regulation of medical practice. The Food and Drugs Act,[169] prohibits the preparation and sale of injurious and adulterated drugs. The Pharmacy and Drugs Act[170] regulates the pharmacy profession and trade in and use of drugs and poisons. The National Drug Policy and Authority Act[171] establishes the National Drug Authority, whose mandate includes ensuring the availability, at all times, of essential, efficacious and cost effective drugs to the entire population of Uganda, as a means of providing satisfactory health care and safeguarding the appropriate use of drugs.[172] The National Medical Stores Act[173] establishes the National Medical Stores, which is charged with the efficient and economic procurement, storage, administration, distribution and supply of medicines and other related goods.[174] These pieces of legislation, if implemented are critical in ensuring that ARVs and other drugs for treatment of opportunistic infections are safe and effective. However, the legislation does not spell out the specific targets that must be met and the benchmarks against which the state's performance and accountability may be weighed.

The Medical and Dental Practitioners Act[175] governs the law relating to medical and dental practice. The Act establishes a Medical and Dental Practitioners Council whose functions include the general supervision and disciplinary control over medical and dental practitioners.[176] Other relevant functions include the protection of society from abuse of medical and dental care and research on human beings.[177] The Council is also charged with the responsibility of disseminating to the medical and dental practitioners and the public, ethics relating to doctor-patient rights and obligations.[178] According to the Act, a registered practitioner may demand reasonable charges for any treatment rendered, or for any drugs prescribed or supplied and shall be entitled to sue for or recover the same, with full costs in any court of competent jurisdiction.[179] However, there are no guidelines as to what amounts to 'reasonable charges' forall drugs and services including ART. The law is legitimating the

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[169] Cap.278, Laws of Uganda.
[170] Cap. 280, Laws of Uganda.
[171] Cap. 206, Laws of Uganda.
[172] Sec. 3 and 5.
[173] Cap. 207, Laws of Uganda.
[174] Sec. 4. A scandal has recently hit the National Medical stores whereby huge amounts of ARVs expired due to negligence. See, B. Simson & H. Nabayunga, 'Health probes ARV expiry', *The Daily Monitor*, Sept. 8, 2006, at 6.
[175] Cap. 272, Laws of Uganda.
[176] Sec. 3 (a) – (d).
[177] Sec. 3 (e).
[178] Sec. 3 (f).
[179] Sec. 42.

commercialization of health care, ignoring the fact that over 38% of the population lives below the poverty line.[180]

According to UDHS (2001), over 50% of health facilities are in urban areas, yet 80% of the population lives in rural areas. Consequently, most of the people utilize the services of traditional health practitioners (THP), including traditional birth attendants (TBAs). THETA has brought TBAs on board as key stakeholders in the PMCT programme. TBAs offer counseling services to HIV/AIDS and make referrals for PMCT, VCT and other related services. THETA has built referral networks between TBAs and the bio-medical health system. TBAs are trained to provide quality health care services as the health care delivery system is improved.[181] It is however disappointing to note that in spite of the role played by traditional health care in the management of HIV/AIDS and other diseases, there is no law regulating the activities and general functioning of THP. There is consequently a need to expedite enactment of the law that will regulate traditional medical practice and eliminate the quacks.

The Uganda Aids Commission Act[182] establishes the Uganda Aids Commission (UAC) whose mandate includes the formulation of policy and establishment of programme priorities for the control of the AIDS epidemic and management of its consequences throughout the country.[183] Other functions include identification of obstacles to the implementation of AIDS control strategies and the dissemination of HIV/AIDS-related information and its consequences.[184] UAC is also charged with supervising all activities relating to the control of the AIDS epidemic, including *inter alia,* health care and counseling of AIDS patients, the handling of socio-economic, cultural and legal issues related to the epidemic and to find a cure for the disease.[185]

The Patents Act[186] grants a lot of protection to patent-holders because it excludes parallel importation and restricts the application for compulsory licenses to very limited grounds.[187] However, the Act contains a number of flexibilities, which when employed could go a long way in enhancing the availability of ARVs. Under the statute, the Ministry of Health may, for the reason of 'vital public interest',[188] including matters pertaining to public health, request patent-holders to surrender

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[180] PEAP, note 11. However, poverty is said to have reduced to 31%. See, UBOS, *Uganda Household Survey* 2005/2006, cited in Patience Atuhaire, 'Poverty levels reduce' *Daily Monitor*, December 14, 2006 at p.1.
[181] Interview with Grace Nanyonga, Library, Information and Research Officer, THETA.
[182] Cap. 208, Laws of Uganda.
[183] Sec. 5 (a).
[184] Sec. 5 (c) and (e).
[185] *Id.*
[186] Cap. 216 Laws of Uganda.
[187] On the rights of the patent holder, see Sec. 25 which grants a patent holder exclusive permission to make, use, exercise and vend the invention. See also Sec. 26 on infringement. On compulsory licensing, see Sec. 30 of the Act.
[188] Sec. 29 (3).

their patent rights in Uganda.[189] It should be noted that unlike the TRIPS agreement, the Patents Act limits the term of a patent to 15 years.[190] To conclude, the legal framework in Uganda is a real 'mixed grill.' Some of the provisions of the law are inadequate. Others sound noble from a human rights perspective, but their implementation is inhibited by constraints that adversely affect the capacity of the state.

3.2 The Negative Consequences of Globalization

One of the hallmarks of globalization from above is the erosion of the state's capacity to realize economic, social and cultural rights such as the right of access to ART. The state is compelled to take measures that adversely impact on the right of WLA to access ART. Because of the dictates of globalization, the state has largely embraced free market economic policies. The state has given a disproportionate weight of priority to economic growth to the detriment of social services such as health care. The following analysis examines the salient aspects of globalization that have a deleterious impact on the state's responsibility to protect the right under inquiry.

3.2.1 Funding for the Health Sector: a Question of Prioritization?

All the key informants disclosed that the most serious bottleneck to the provision of ART is a lack of sufficient funding. Funding is critical for the provision of both physical and human infrastructure. Although the Abuja Declaration recommends that states should allocate at least 15% of their national budgets to health,[191] Uganda spends only 8% on health and certainly this has serious implications on the provision of ART.[192] But how can this funding problem be explained?

The institutions of globalization, especially the World Bank and the IMF argue that increasing public health spending undermines macroeconomic stability.[193] It is the macroeconomic model designed by these institutions that sets rigid budget ceilings for each ministry including the Ministry of Health.[194] It is also important to note that the IMF seems to prefer prevention strategies to treatment measures, because the costs involved are likely to have inflationary tendencies.[195] Another possible explanation of the funding problem is the debt crisis. Uganda's foreign debt is estimated at approximately US$ 4 billon and the country's net present value of debt to exports stands at 305%.[196] There is no doubt whatsoever that the debt burden undermines the state's capacity to provide social services

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[189] See, sec. 29 (1) and (3). See also, sec. 35.
[190] Sec. 31.
[191] Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases (2001) OAU/SPS/ABU/326.
[192] *Id.*
[193] Interview with Ministy of Finance official who requested anonymity.
[194] Interview with Dr. Nelson Musoba, Ministry of Health, Kampala.
[195] *Id.*
[196] PEAP, note 11 at xvii.

to its people. The external debt is not sustainable. According to the PEAP, external loans currently account for 40% of donor funds in any given year.[197] As a Highly Indebted Poor Country (HIPC), Uganda has benefited from debt relief.[198] Money saved from debt relief is supposed to be invested in poverty alleviation programmes, which include the minimum health care package as outlined in the HSSP.[199] However, debt relief is simply that—a relief, which assumes that HIPC countries continue to borrow to increase spending on poverty reduction leading to future debt build-up. For example, in 2000, debt relief of US$ 1 billion was pledged, but since then Uganda has borrowed US 1.5 billion.[200] As the PEAP admits,

> *Excessive aid dependency inevitably impinges on the sovereignty of the aid recipient and constrains its economic and budgetary choices, which is not consistent with the development of a healthy and equal relationship between aid recipients and the donors, based on mutual respect. Reducing dependency on aid is crucial for the development of democracy and the accountability of government.*[201]

Debt relief and donor dependency generally are not a panacea for the human rights violations resulting from the debt burden. In my considered opinion, the only sustainable solution to the debt burden is debt cancellation with a major condition that significant portions from the savings from debt cancellation go toward social welfare programmes like health care and education. Otherwise, debt service repayments will continue to undermine the state's capacity to meet its minimum core obligations such as enhancing access of WLA to ART.

The funding problem can also be explained by a lack of democratic accountability. Health care issues such as access to ART are not prioritized. One key informant told this researcher that,

> *Let me be candid with you. Money for ART and other related health issues would be readily available if these were taken as a priority. If all the money that goes into ostentatious expenditure was channeled to ART, all urban and rural public health centres would have ART and the attendant requirements like equipment and personnel.*

Indeed, the NRM government has incurred a lot of expenditure on building state patronage. A good amount is spent on presidential advisors, Resident District Commissioners, parliamentarians and other officials that do not directly contribute

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[197] *Id.*
[198] See, World Bank, Uganda Country Brief (2005), available at http://web.worldbank.org/SITE/EXTERNAL/COUNTRIES/AFRICAEXT/UGANDAEXTN/0, accessed July 3, 2006.
[199] *Id.*
[200] PEAP, note 11 at 41.
[201] *Id.*

to human development.[202] It should be noted that globalization requires benevolent states and regimes that must be market-efficient in suppressing and deligitimating human rights practices. Without much donor support, the NRM would not be able on its own to spend as it does on such patronage. Furthermore, donor funds are sometimes consumed by corruption as evidenced by the Global Fund on HIV/AIDS, Malaria and Tuberculosis where state functionaries swindled millions of dollars.[203] But this is only one half of the globalization story; the other relates to the international trade regime and its consequences for the protection of the right.

3.2.2 The Patent Regime

The international patent regime has rendered pharmaceutical products such as ARVs too expensive and at times inaccessible for poor countries like Uganda. The granting of a patent over the manufacture of a medicine or pharmaceutical product gives the patent holder a monopoly.[204] Under the TRIPS agreement, such manufacturer has a monopoly over the patent for a period of 20 years. This is justified on the grounds that the patent holder must recoup the costs invested in the research and development of the patented product or processes. The patent protection in the TRIPS agreement blocks the importation of low cost medicines and increases drug prices considerably, pushing them beyond the means of the majority. As Musungu has observed,

> *Although various justifications are given for granting patents, one clear effect is that the cost for the covered technology is set at an artificially high level. For medicines, the high prices for new medicines resulting from the mandatory requirements for patent protection under TRIPS in developing countries have seriously compromised the ability of communities, governments, and other players in the health sector to effectively manage infectious and other diseases.*[205]

The state has to spend a disproportionate amount of funds on medical supplies leaving little for other critical health needs such as infrastructure development and the training of health personnel. It can thus be stated that the strengthening of patent protection for pharmaceutical processes and products under TRIPS is a serious constraint to the enjoyment of the right to health generally and of the right of WLA to access ART in particular.

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[202] The media is full of stories about the bloated administrative expenditure in Uganda. See for example, Felix Osike, 'LC. Bosses to get 12billion,' *Sunday VIsion*, May 15, 2005; Denis Ocwich, 'Can Uganda's economy support more districts?' *New Vision*,, August 8, 2005.

[203] The scandal led to the institution of a commission of inquiry which implicated key government functionaries including members of parliament, security personnel and ministers. By the time of writing this report, the state had not prosecuted key figures, including the implicated minister of health.

[204] Musungu 2005.

[205] *Id.* On the problems created by the patents regime in the context of the protection of public health, see also, Sacco, 2005, at 105-128.

It should be noted that the TRIPS agreement permits states to take measures for the protection of public health.[206] This article provides policy space to take measures for the protection of the right under investigation. It should also be noted that though not explicitly couched in human rights terms, the preamble to the WTO agreement provides that the objectives of the trading system include the improvement of living standards for all people. The Doha Declaration on the TRIPS agreement and Public Health stresses that the right to health plays an essential role in the interpretation of the agreement. The Declaration states as follows:

> *We agree that the TRIPS agreement does not and should not prevent members from taking measures to protect public health. Accordingly, while reiterating our commitment to the TRIPS Agreement, we affirm that the Agreement can and should be interpreted and implemented to protect public health and, in particular, to promote access to medicines for all.*[207]

It should be noted that the TRIPS Agreement contains a number of flexibilities that could be utilized to protect the right to health especially access to ART. The agreement allows parallel importation, that is, the importation without the patent owner's approval, of products marketed by the patent owner at relatively cheaper prices in another country.[208] The agreement also permits compulsory licensing, that is, the production of drugs without the patent owner's approval.[209] Two conditions must be met. The state or company authorized on its behalf must have failed to procure a voluntary license from the patent owner. Secondly, compensation should be paid to the patent owner.

It is important to note that the so-called flexibilities may indeed be of no serious value for least developed countries like Uganda. This is because the countries have limited research and development capacity. Given that most of the ART is donor funded, only patented drugs may be availed to the recipient country. Countries like India do not provide product patents on pharmaceuticals and food products. Consequently, Uganda may acquire generic drugs from such countries. But this requires sufficient funds, which the state may not have. Compulsory licensing may also not be possible for poor countries like Uganda, given that locally-based companies may not have the capacity to compete with the global pharmaceutical companies who reap from economies of scale and sell at relatively low prices.[210]

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[206] Article 8.
[207] Para. 4 of the Declaration. The Declaration is cited in F.M. Abbott' (2002).
[208] *Id.*
[209] *Id.*
[210] *Id.*

3.3 Inadequate Attention to a Rights Based Approach (RBA) in the Policy Framework

3.3.1 What is a Rights Based Approach?

According to WHO, the RBA refers to the processes of 1) using human rights as a framework for health care development; 2) assessing and addressing the human rights implications of any health policy, programme or legislation; 3) making human rights an integral dimension of the design, implementation, monitoring and evaluation of health related policies and programmes in all spheres, including political, economic and social.[211] The RBA requires that policy makers and implementers pay attention to those population groups considered most vulnerable in society such as poor women and men.[212] The approach demands that a gender perspective be employed in the design and implementation of policies, by recognizing that biological and socio-cultural factors play a significant role in influencing the health of men and women.[213] There should be free, meaningful and effective participation of beneficiaries of health development policies or programmes in decision-making processes, which affect them.[214] The policies should articulate the concrete obligations to respect, protect and fulfill the right to health. The RBA also requires the identification of benchmarks and indicators to ensure monitoring of the progressive realization of right to health.[215] What is the potential of the relevant policy framework in the protection of the right to health generally and the right to health care of WLA in particular?

3.3.2 Policy Responses to Protection of the Right to Health Care of WLA

3.3.2.1 'The Poor Do Not Fall Sick'

All the respondents identified poverty as a major hindrance to access to and utilization of health care services including ART. One respondent told this researcher,

> *At times the health worker prescribes for me drugs, which are not available at the hospital, and I am advised to buy them from elsewhere. But where is the money? At times I do not buy the drugs and wait for the next visit to the hospital.*

Apart from the cost of some of the drugs, other factors cited by the respondents are very long distances and the transport costs incurred in going to the hospital. Another respondent stated,

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[211] WHO 2002 at 16-17.
[212] *Id.*
[213] *Id.*
[214] *Id.*
[215] *Id.*

> *I reside in Mwizi, about 30 kilometres from Mbarara town. To come here, I need shs. 4000 for transport to and from town. It is difficult for me to raise this money every time I want to travel for treatment. At times I do not go for the treatment. Man, 'the poor do not fall sick'.*

Because of the foregoing factors, some women seek care only when the symptoms have become debilitating and discontinue treatment when the symptoms have disappeared. Yet, failure to adhere to the prescribed regimen may produce drug resistance and affect the efficacy of the treatment. Indeed, there is a problem of drug abuse through under dosing or the sharing of doses, which impacts negatively on the effectiveness of the drug prescribed. As one respondent stated,

> *Last month I received drugs from the hospital to take me for a month. But as I talk now, I do not have any drug. I gave some to one of my close friends who is HIV positive. But I cannot disclose that information to the health workers because they will abuse me.*

Asked as to why her close friend could not go to a health facility for treatment, the respondent was evasive but on further probing she stated that her friend did not have money for transport to the hospital since the health centre where she had tested positive had long run out of drugs. The respondent disclosed that she did not receive extensive counseling on adherence before and after initiation of the drugs (ARVs) and did not see anything wrong with helping a friend. Probably, if there had been adequate monitoring and follow-up support by the health workers, this pathetic situation would have been detected on time. The fact that the respondent feared to disclose the information to the health workers tells a lot about the latter's attitude. It is true that the majority of respondents stated that they discussed their sickness freely with the health workers during counseling sessions. However, some respondents reported that they could not discuss any social problems that affect adherence to the treatment regimen.

It is important to note that although women are major sources of economic wealth in many rural areas, these women have limited control over their generated income due to cultural taboos and traditional practices. One widow from Rubindi, a rural area, told this researcher that,

> *When my husband fell sick, he did not have any money to take him to hospital. Though he was employed as a bricklayer, he spent all his earnings on alcohol. One day, he called a family meeting and I was ordered by my in-laws to sell all the beans and maize I had harvested in order to raise money for his transport and hospital bills. I had no choice but to comply. My husband was taken to Mbarara hospital and he tested HIV positive. I spent over two months attending to him. Because he had reported to hospital late, he eventually died. After burial, I discovered that my in-laws had sold the few pieces of land my husband owned ostensibly to raise money for his treatment. But they never brought any money to the hospital. Our two daughters had also dropped out of school and were engaged in casual labour for survival. One of them went away and I hear*

> *she is a prostitute in Masaka. Two weeks after the burial of my husband, a family meeting was called and I was told that because I infected my husband with HIV, I had to leave their home. I reported the matter to the Local Council (LC) officials who sided with my in-laws. I was devastated. In all our 14 years of marriage, I had never cheated on my husband although I had received information that he had multiple partners in our village. I was allowed to pack only my clothes. I went back to my father's home. A childhood friend advised me to go for an HIV test, which turned out positive. At first I was reluctant to go for the test because I feared that I would be isolated. But on further encouragement by my friend, I obliged. Presently, I am on drugs but some are very expensive.*

The foregoing story reveals a number of issues that are often overlooked or neglected by the policy framework. Women, especially from poor settings have a limited control over physical and financial resources. The resources available are spent on their spouse or other family members. By the time a husband dies, family resources have usually dwindled to the point where women are either unable or unwilling to seek medical care. Largely because of negative cultural practices and inequitable gender relations, these women are unable to leave a relationship even when they suspect or know that their partner has been infected with HIV. There is also a problem of inheritance laws, customs and practices that favour the husband's relatives. When women lose their husbands or partners to AIDS, they are often denied their inheritance rights, leaving them more destitute and even more vulnerable than before. Women may also not go for counseling and treatment for fear of stigma and discrimination in the society where they reside. As a result, they may not promptly take HIV tests and by the time they do, the infection is in an advanced stage thereby making the ARV treatment somewhat ineffective. These factors plunge them deeper into poverty. Consequently, for women, the problem moves beyond the '**A**bstain; **B**e Faithful; use a **C**ondom' (ABC) approach championed by the policy framework. Though this approach expands the awareness of the HIV/AIDS pandemic, it may overlook critical factors that women confront.

To give credit where it is due, the policy framework recognizes the impact of poverty on the ability to access health care facilities, goods and services. The PEAP—which is the 'over-arching framework to guide public action to eradicate poverty'[216]—notes that poor people, who do not have the capacity to utilize private health care, should have effective access to the public health care system. HIV/AIDS is identified as one of the priority areas to be tackled through a number of actions including, the public provision of ARVs. The detailed specific targets for prevention and control of HIV/AIDS are contained in the HSSP and they include the scale up of voluntary counseling and testing (VCT) and prevention of mother to child transmission (PMTCT) services at Health Centre III by 2010. The targets also include increasing the population of Health Centre IV offering comprehensive HIV/AIDS care with ART by 2010 of 75%.[217]

[216] PEAP, note 11 at xv.
[217] HSSP, at 16 and 33.

The intention of the state to achieve the laid down targets is commendable. However, the policy framework is underpinned by the ideology of market forces. It is full of the World Bank-IMF standard prescriptions, which include an increased role for the market and the private sector in health service delivery. Health care provision is not looked at from a human rights perspective but from the desire to increase economic growth and the maintenance of macro-economic stability. Although the policy framework promises that the state may intervene where markets do not promote equity, even here, the state may contract NGOs or the private sector to provide services. It should be noted that liberalization and the entry of private providers of services does not necessarily bring about more efficient service provision. UNDP has correctly observed that,

> *The supposed benefits of privatizing social services are elusive, with inconclusive evidence on efficiency and quality standards in the private relative to the public sector. Meanwhile, examples of market failures in private provisioning abound.*[218]

It should further be noted that the emphasis of the free market and privatization is incompatible with the full protection of social, economic and cultural rights of the poor, such as access to ART. The success of the policy framework must be judged on the basis of its capacity to contribute to the dignity of the vulnerable and not simply promoting the interests of the private sector.

Thus, although the Antiretroviral Treatment Policy aims at universal access to ART to all that are clinically eligible to it,[219] this may not be possible unless the constraints posed by the macroeconomic framework are concretely addressed. For example, the policy does not provide for the control or regulation of the private sector and the prices they impose. The policy does not concretely address issues of equity. The policy ignores the fact that because of their poverty, some of the PLHA cannot afford expensive CD count tests, which are a prerequisite for starting ARVs. Indeed, all the respondents from rural areas stated that they had to travel to Mbarara hospital because of the absence of machines to carry out the tests. It should be noted that some of the testing machines are sophisticated and there is a limited number of technical personnel to perform the tests. Even laboratories to carry out simple HIV tests are not readily available in rural areas.[220] A careful analysis of the policy shows that it does not lay down a mechanism of determining who are the vulnerable members of society that should access free or subsidized tests or drugs. The policy does not adequately recognize the impact of inequitable gender relations especially domestic violence and abuse on the accessibility and utilization of ART.

[218] UNDP 2003 at 113.
[219] Ministry of Health 2003a.
[220] Interview with a health worker at Mbarara Hospital who preferred anonymity

3.3.2.2 Sick, Tired, and Hungry Too

The policy framework does not seriously consider the interconnectedness and indivisibility of rights.[221] For example, although the Antiretroviral Policy stresses access to ARV treatment, it ignores crucial rights such as access to food and an adequate standard of living. And yet, available evidence shows that people on ARVs need adequate food as one respondent stated,

> *Those drugs! There is one drug I got from the hospital. When I took it I got severe pains and became very weak. I left the drug. For a week, I never swallowed any tablets except 'hedex', a painkiller. I was very hungry but there was no food. It was a period of severe drought. When I went back to hospital, I was prescribed another drug and advised to eat a lot of food. But where was I to get the food from?*

Another respondent told this researcher that,

> *One time I misread the instructions. I did not take drugs for two days but when I resumed, I developed side effects. I could not dig or do any other serious work for 2 days.*

It can be seen from the above, that WLA may not adhere to ARV drugs because of reasons ranging from lack of adequate food and education to side effects of the drugs. The guiding principles of good ART include, freedom from serious adverse effects, efficacy of the chosen drug regimen and ongoing support of the patient to maintain adherence.[222] Adherence throughout the entire course of ART is an essential part of any successful treatment programme. Patients have to take at least 95% of their pills in order to respond well.[223] From a medical perspective, this sounds noble. But why don't people on ART adhere to the treatment regime?

Merely looking at WLA and access to ART from a medical perspective is not sufficient. A gender analysis of the socioeconomic and cultural causes of why WLA do not access ART is necessary in order to achieve a more comprehensive picture of the magnitude of the problem. Gender relations play a crucial role in access to and utilization of ART. A typical working day of the women shows that they are constantly kept under time pressures because of the gender roles they play. WLA face a triple jeopardy: they suffer as individuals because of their sickness, as mothers and as caregivers.[224] Because of their gender roles, women hardly get enough time to effectively utilize ART in accordance with the doctor's prescriptions. Asked whether she attends hospital on all the appointed days, one respondent stated,

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[221] The Vienna Declaration states that all human rights are indivisible, interrelated and interdependent.

[222] *Id.*

[223] *Id.*

[224] On women's gender roles, see, B.K.Twinomugisha, note 49.

> *I have to look after the family. I have to fetch water, firewood, prepare the family meal, dig and do all that the woman is supposed to do. By the time I remember that I am supposed to go for treatment, the day has already gone and I am even exhausted.*

It should also be noted that all the respondents stated that they do not take any meaningful rest from work. The right to leisure, which is critical for PLHA, is alien to the women. And yet, as seen above, some of the drugs intensify their weakness. But for the sake of the survival of their families, they have to work. One respondent stated,

> *Unless I fall seriously sick, I have to work whether I am feeling well or not. Recently, I woke up with nausea and some little fever. However, I thought that it might be a problem of the bad weather. Because it was a planting season, I had to attend to my garden. I almost passed out.*

The policy framework does not take into account the socioeconomic realities of WLA. The policy for the reduction of MTCT provides as follows:

> *Ideally, a mother who is HIV positive should not breastfeed. However, if the woman has to breastfeed because of social or economic reasons, then exclusive breastfeeding for about three months is recommended. Emphasis will be put on locally available products for replacement feeding and mothers will be trained on their proper preparation and use.*[225]

It may not be helpful to advise poor infected mothers to breastfeed their children when they lack the resources to access substitute milk, replacement foods or clean and safe drinking water. For some women breastfeeding is a matter of prestige within the family. Breastfeeding is often an integral part of motherhood and those who do not breastfeed are seen as bad mothers. Asked whether she is currently breastfeeding, one respondent on *nevirapine*, stated,

> *How can I stop breastfeeding? My mother in law says that any woman who does not breastfeed is not fit to be a daughter in law of any sensible and respectable woman.*

Thus, although the policy framework discourages breastfeeding,[226] the mother has to weigh the social risks accruing from not breastfeeding her child. She has to seriously consider what impact the decision will have on the relations with

[225] Ministry of Health 2003b.

[226] Policy makers need to be cautious about breast milk substitutes. The International Code for the Marketing of Breast milk Substitutes, adopted by the WHO in 1981, forbids all promotion of breast milk substitutes. However, TNCs such as Nestle not only continue their promotional campaigns for their products and attempt to discredit breastfeeding, they also put pressure on the WHO and on governments to avoid or limit the implementation of the Code. On this point, see IBFAN, *Press Release*, January 21, 2004.

her husband and family. It should also be noted that some women are socialized to believe that the health of their infants and families takes precedence over their own health. A pregnant woman readily accepts ART on reduction of MTCT even if she has not received care. Mothers need to access ART in order to enhance their health and ensure quality survival of their children.

3.3.2.3 Stigma and Gender Based Violence

Some of the women seek care discreetly. Because of the associated stigma of HIV/AIDS and fear of violence from their husbands, they do not want their husbands, in-laws and the wider community to know that they are receiving care. One respondent stated,

> *I cannot let my husband know that I receive treatment and care. I have to make sure that no one at home knows that I have gone to hospital. Should I suspect that someone is likely to know about my plans, I miss going for the treatment. I fear reporting to my husband who has always said that should I ever infect him with HIV, he would kill me. In fact when I tested positive, I never informed him.*

Indeed most of the respondents agreed that fear of violence from their partners is a serious constraint to access to and utilization of ART. However, two women from Ruti trading centre, a suburb in Mbarara town categorically stated that they freely discuss their health situation with their partners. One of the women told the interviewer,

> *Both my husband and I are teachers by profession. When I tested HIV positive, I first hid the information from him. However, I remembered the old adage that 'if you hide meat from the fire, where do you roast it?' I told him the truth. Of course he was shocked, but after a week or so he agreed to go for a test. He also tested positive. After some counseling, he accepted the situation. He never quarreled, abused or beat me. He is also on ARVs. We freely discuss our sickness. There is no apportionment of blame at all. At times we visit the hospital together for treatment and counseling. Because of the treatment we receive, we look healthy. No one at school suspects that we are HIV positive.*

The findings also revealed that single women who are engaged in petty businesses in town freely access ART without seeking anybody's permission. They also have some degree of control over their meagre income. However, these single women also face stigma and discrimination in their places of work. As one respondent stated,

> *I tested HIV positive in 2004. I was vomiting and had severe diarrhea. I also had a rash all over my body. I was generally weak. Whenever I could feel a little better, I would go to my small business in the market in town. Fellow traders began gossiping about my sickness. In fact one woman with an adjacent stall to mine shifted to another market. I felt devastated. However, in 2005, I was put on ARVs and now I feel okay. I can now freely mix with other women.*

The foregoing voices show that women's access to ART is affected by their socioeconomic status, and particularly by the level of education and control over income. The voices also show that ART may reduce stigma because some of the women who receive counseling and treatment at the appropriate time appear healthy and are able to resume working for themselves and their families.

The question is: where are the men in all this? A number of studies have found that though men are aware of the existence of some of the programmes on HIV/ AIDS, they are not actively involved in these programmes. Men play a big role in the health care seeking behaviour of their wives or partners.[227] Married women who depend on their husbands are sometimes forced to ask for permission from their husbands or other senior family members before they access care. One respondent stated,

> *My husband is a mason. He is the one who earns money and supports the family. I cannot afford transport to Mbarara town. I have to ask him money for transport and meals. If he does not want me to go, he merely says that he is broke.*

Programmes like PMTCT that focus on mothers ignore the fact that men are just as much a part of the solution. Clearly, the lack of involvement of men in the programme undermines its success.

3.3.3 Lack of Democratic Participation in the Policy Framework

The legal foundation for democratic participation is contained in the Constitution, which provides as follows:

> *The State shall take all necessary steps to involve the people in the formulation and implementation of development plans and programmes which affect them.*[228]

WHO and UNAIDS also stress that the people have the right and duty to participate individually and collectively in the planning and implementation of their health care.[229] The two organizations have stated that active participation of PLHA, including women, is critical when designing effective strategies for treatment and care.[230] WLA need to be involved at all levels to consider their perspectives in the planning, implementation, monitoring and evaluation of relevant programmes.[231] The PEAP also observes that participation and access to information are necessary conditions for the well-being of a population and for enhancing human development.[232]

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[227] See for example, Admchak 2002.
[228] Objective X.
[229] WHO/UNAIDS 2004.
[230] *Id.*
[231] *Id.*
[232] PEAP, *op cit.*, at 147.

However, the policies and programmes are formulated and implemented in a top-down and undemocratic fashion. It was clear from the interviews conducted for this study, that WLA are not aware of the various policies that have a bearing on the right in question. Policy makers should seek the perspectives of WLA. Listening to the concerns of WLA in relation to the programmes designed for their benefit is an obligation, not simply a favour. Policy makers and implementers should carefully listen to the actual constraints faced by WLA in their struggle to access care. In the next section, I draw conclusions from the study findings and present a number of recommendations.

IV. SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

4.1 Conclusions

4.1.1 Legal Status of the Right and Attendant Obligations

Legally, WLA have a right to health care, which includes access to ART. This right is contained in various international and regional human rights instruments to which Uganda is party. Both the state and non-state actors have obligations towards protection of this right. Institutions of globalization, most notably the World Bank, IMF, and WTO have a continuing obligation to ensure that they do not impose policies on the country that negate the right to health generally and the right to health care of WLA in particular. Private persons, including individuals also have obligations to respect and uphold the right.

Though the right under inquiry is not expressly recognized under the Bill of Rights in the 1995 Constitution, it can be protected through the application of norms contained in international and regional human rights instruments. Through public interest litigation by individuals or civil society organizations, courts can be moved to invoke the objectives in the Constitution that have a bearing on the right. The right can also be protected through an expanded interpretation of the more developed civil and political rights contained in the Bill of Rights.

4.1.2 Constraints to Protection of the Right

It is one thing to have a human right enshrined in a legal instrument, yet another to have it realized by the intended beneficiaries. Consequently, there are both external and internal constraints to protection of the right in issue. External constraints are largely manifested in the globalization process which negatively affects the state's capacity to protect the right through liberalization and privatization, cuts on public funding and an international trade regime that renders medical supplies like ARVs too expensive for countries like Uganda. Internal constraints revolve around a weak legal and policy framework, characterized by a lack of democratic participation, transparency and accountability. The policies in place are largely top-down and do not place the individual woman at the centre of the policymaking and implementation process. Gender relations, which negatively affect the capacity of WLA to access ART, are not adequately addressed

by the policy framework. On the whole, there is inadequate attention to a RBA in the design and implementation of policies with a bearing on protection of the right.

4.2 Recommendations

4.2.1 The Legal Framework

There is an urgent need to explicitly recognize the right to health care in the Constitution, which could clear any misgivings about the justiciability of the right. However, recognizing the right in the Constitution is not sufficient. Legal and policy instruments must underpin the Constitution. To this end, there is an urgent need for a health legislation that makes it unequivocal that the state is under an obligation to provide adequate, affordable and accessible health care, including ART to its people with special attention to the poor and vulnerable. The legislation should contain measurable benchmarks and targets against which state performance can be measured. The legislation should also include provisions on periodic review, monitoring and evaluation of performance of the relevant health sectors. It should also contain offences and penalties against officers who may misappropriate essential drugs, or negligently fail to address stock-outs in hospitals or health centres, or fail to distribute the drugs on time like the recent case of Uganda Medical Stores. The legislation should also address access to health care provided by private providers, by including fees structures or guidelines in order to minimize exploitation of patients. Participation should not depend on the goodwill of the state. The legislation should expressly provide for the participation of the population, including WLA in the formulation and implementation of health related legislation and in those policies that affect them. The legislation should also stress the interconnectedness of rights, by for example obliging the state to provide food to women on ART.

4.2.3 Judicial Protection

Courts can play a crucial role in the alleviation of poverty by addressing issues of social justice such as access to health care. Judicial officers—especially judges of the higher courts—can be creative in their interpretation of relevant constitutional provisions to compel the state to meet its obligations under international human rights law. Where the Constitution is silent, judges can invoke the provisions of international human rights instruments. Article 45 gives them the mandate to look at other rights not specifically provided for in the Constitution. Judges can also rely on national case law within the Commonwealth that has tackled the right in question. The judges should also devise creative means of rendering national objectives and DPSP justiciable. The judiciary cannot of course overlook the resource constraints of the country. However, they can make it clear that for the poor and vulnerable, the state must show that it has utilized the available resources towards the protection of their right to health care, including access to ART. Justiciability of the right to health care is one of

the ways of controlling how the available resources are being prioritized and spent.

The Uganda Human Rights Commission (UHRC) should utilize its wide mandate to protect such rights as access to health care. It can investigate at its own initiative or on a complaint made by a person or group of persons, the violation of human rights. It has powers to monitor the government's compliance with international obligations on human rights.[233] Consequently, the UHRC should require the state to periodically account as to the extent to which it is meeting its obligations to protect the right in question.

4.2.4 Tackling Policy Constraints

4.2.4.1 Applying a Rights Based Approach

The state and the institutions of globalization should apply a human rights approach in the design, implementation, monitoring and evaluation of policies in order to avoid adverse impacts on the right to health care generally and the right to health care of WLA in particular. In dealing with these institutions, the state should make it clear that the obligation to protect such rights is non-negotiable. The state can firmly refer to its obligations under the relevant international instruments to back its position. It is extremely important to ensure that WLA participate in the design, implementation and evaluation of all the policies intended for their benefit. The interests, realities and concerns of WLA must be integrated into the process right from the stage of planning up to the point of implementation.

4.2.4.2 Civil Society Organizations (CSOs)

CSOs engaged in traditional human rights work should take up activities in the economic and social arena. As such, they should be more directly engaged in poverty reduction processes by ensuring that sufficient resources have been allocated to the health sector. They should also follow up on how the allocated money has been utilized especially for priority areas like ART. CSOs can challenge the state to demonstrate that it has employed the available resources maximally towards the realization of the right in question. At the same time, CSOs can engage in public interest litigation, which the Constitution recognizes.[234] This is particularly important given the poverty levels where the potential litigants may not be aware of their rights let alone being able to meet legal expenses.

[233] Article 52 of the Constitution
[234] Article 50 of the Constitution.

4.2.4.3 Increased Funding

Sufficient funding should be invested in health and the available funds should be allocated in a cost effective and fair manner, paying attention to vulnerable groups such as WLA. A Rights Based Approach to health recognizes that policy makers are faced with painful choices. However, given the devastating impact of HIV/AIDS, lives could be saved if good quality ART was accessible and affordable for WLA in need. This would enhance the protection of their right to life. Relevant offices should increase the investigation of cases of corruption. Corrupt officials should be prosecuted and any stolen funds must be refunded.

4.2.4.4 Tackling Gender Relations

Tackling gender relations is no easy task because it involves adjusting entrenched and deeply embedded norms of behaviour and beliefs about gender roles. Incorporating a gender perspective in all policies, programmes and practices is the starting point. Gender relations must form an integral part of all spheres of life including family and community life. As such, Policy makers should recognize the economic value of women's domestic labour by including it in official economic statistics. Policy makers and implementers should target both men and women. Men must be involved in education strategies affecting women's health. Education strategies should focus not only on changing sexual behaviour but also on the dissemination of rights and changing existing gender relations. Men should be made to understand that they also have obligations to respect women's human rights.

Reforms are needed in the area of inheritance and property rights to ensure that women can securely inherit property of their deceased husbands. In this vein, Parliament should pass the Domestic Relations Bill. However, having a law in place is not enough. There is a need to sensitize women, husbands, families, and communities about the contents of the law. The state should take steps to end cultural practices that deny women access to physical resources and the right to benefit from their toil and labour. There should be zero tolerance against domestic violence and perpetrators should be subjected to the law. Women who report such violence should be supported. VCT sessions should include life skills against domestic violence. It should be noted that men are both instigators of violence and essential to the solution. Thus, men should be encouraged to examine their own attitudes and behaviours towards women.

There is need to create opportunities for women to escape poverty through sustainable programmes that improve their vocational and business skills. Policy makers must move beyond the ABC approach of AIDS prevention to a more comprehensive and long term strategy that recognizes the stark reality that feminization of HIV/AIDS is closely intertwined with poverty and harsh living conditions. There should be free treatment for HIV/AIDS and other opportunistic infections. To enhance physical accessibility of ART, all Health Centre IV should have ART and qualified personnel to obviate the need for clients to travel long

distances to Mbarara. Ambulance services should be availed at strategically located health facilities to provide transport for emergency treatment. Finally, there is a need to increase support to organizations such as THETA so as to train more THP especially TBA in the handling and referral of WLA.

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