

**PROTECTION OF ACCESS TO ESSENTIAL TREATMENT FOR PEOPLE LIVING WITH  
HIV/AIDS IN UGANDA FROM A HUMAN RIGHTS PERSPECTIVE**

**By**

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**Submitted in partial fulfilment of the requirements of the degree LLM (Human Rights  
and Democratisation in Africa) Faculty of Law, Centre for Human Rights, University of  
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**30 October 2005**

## DECLARATION

I, LILIANA TRILLO DIAZ, hereby declare that this dissertation is my original work, and other works cited or used are clearly acknowledged. This work has never been submitted to any University, College or other institution of learning for any academic or other award.

Signed: .....

Date: .....

This dissertation has been submitted for examination with my approval as University supervisor.

Signed:.....

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Date:.....

## **DEDICATION**

I dedicate this work to my husband, Dr. Thomas Simonson, for his unconditional support and faith in my academic project. I would like to dedicate it also to the people living with HIV/AIDS in Uganda and to those that dedicate their lives to improving their conditions.

## **ACKNOWLEDGEMENT**

My thanks go to the Centre for Human Rights, at the University of Pretoria, and to the Human Rights and Peace Center (HURIPEC), at Makerere University, for having excelled in their respective tasks as hosting institutions during this academic year. I owe a special word of thanks to Prof. Frans Viljoen, academic director of this LLM, for his assistance in the choice of the topic; to Prof. Mikelo Hansungule, for his helpful comments; and to Prof. Joe Oloka-Onyango, director of HURIPEC, for his kind hospitality and for having revealed us the historical side of Kampala. My profound admiration to all of them for their brilliant academic contributions, guidance and dedication to the students.

This study was carried out under the supervision of Dr. Ben Kiromba Twinomugisha of the Faculty of Law at Makerere University. I wish to thank him most sincerely for his diligent and valuable comments.

My profound gratitude goes to all key informants who patiently answered my questions and kindly assisted me in my study.

## LIST OF ACRONYMS

|               |  |
|---------------|--|
| <b>ACHPR</b>  | African Charter on Human and Peoples' Rights                               |
| <b>ACRWC</b>  | African Charter on the Rights and Welfare of the Child                     |
| <b>AG</b>     | Attorney General   |
| <b>AGHA</b>   | Uganda AIDS Advocacy Network   |
| <b>ANC</b>    | Antenatal clinics  |
| <b>ART</b>    | Anti-retroviral treatment  |
| <b>ARV</b>    | Anti-retroviral  |
| <b>ATP</b>    | Anti-retroviral Treatment Policy for Uganda                                |
| <b>CC</b>     | Constitutional Court   |
| <b>CEDAW</b>  | Convention on the Elimination of All Forms of Discrimination against Women |
| <b>CESCR</b>  | Committee of Social, Economic and Cultural Rights.                         |
| <b>CRC</b>    | Convention of the Rights of the Child                                      |
| <b>DIIS</b>   | Danish Institute for International Studies                                 |
| <b>EAJPHR</b> | East African Journal of Peace & Human Rights                               |
| <b>EML</b>    | Essential Medicines List   |
| <b>GC</b>     | General Comment  |
| <b>GF</b>     | Global Fund to Fight AIDS, Tuberculosis and Malaria                        |
| <b>HAG</b>    | Health Rights Action Group   |
| <b>HEPS</b>   | Coalition for Health Promotion and Social Development                      |
| <b>HR</b>     | Human rights   |
| <b>HRC</b>    | United Nations Human Rights Committee                                      |
| <b>HRW</b>    | Human Rights Watch   |
| <b>HSSP</b>   | Health Sector Strategic Plan   |
| <b>ICC</b>    | International Criminal Court   |
| <b>ICCPR</b>  | International Covenant of Civil and Political Rights                       |

|               |   |
|---------------|---|
| <b>ICERD</b>  | International Convention on the Elimination of All Forms of Racial Discrimination |
| <b>ICESCR</b> | International Covenant of Social, Economic and Cultural Rights.                   |
| <b>ICG</b>    | International Crisis Group  |
| <b>IDP</b>    | Internally displaced people   |
| <b>IFIs</b>   | International Financial Institutions  |
| <b>IMF</b>    | International Monetary Fund   |
| <b>IPR</b>    | Intellectual property rights  |
| <b>LDC</b>    | Least Developed Country   |
| <b>LRA</b>    | Lord Resistance Army  |
| <b>LRC</b>    | Law Reform Commission   |
| <b>MHCP</b>   | Minimum healthcare package  |
| <b>MISR</b>   | Makerere Institute of Social Research   |
| <b>MoF</b>    | Ugandan Ministry of Finance, Planning and Economic Development                    |
| <b>MoH</b>    | Ministry of Health  |
| <b>MSF</b>    | Medecins sans Frontieres  |
| <b>MTCT</b>   | Mother-to-child-transmission  |
| <b>NDA</b>    | National Drug Authority   |
| <b>NGO</b>    | Non-governmental organisation   |
| <b>NHP</b>    | National Health Policy  |
| <b>NODPDP</b> | National Objectives and Directive Principles of State Policy                      |
| <b>NOPA</b>   | National Overarching Policy on HIV/AIDS   |
| <b>NSF</b>    | Revised National Strategic Framework  |
| <b>OAU</b>    | Organisation of African Unity   |
| <b>PEAP</b>   | Poverty Eradication Plan  |
| <b>PEPFAR</b> | United States President's Emergency Plan for AIDS Relief                          |
| <b>PHC</b>    | Primary Health Care   |

|                |  |
|----------------|--|
| <b>PRSP</b>    | Poverty Reduction Strategy Papers                                  |
| <b>R&amp;D</b> | research and development   |
| <b>SA</b>      | South African  |
| <b>SAJHR</b>   | South African Journal on Human Rights                              |
| <b>SC</b>      | Supreme Court  |
| <b>TASO</b>    | The AIDS Support Organisation                                      |
| <b>TB</b>      | tuberculosis   |
| <b>TOI</b>     | Treatment of opportunistic infections                              |
| <b>TRIPS</b>   | Agreement on Trade-Related Aspects of Intellectual Property Rights |
| <b>UAC</b>     | Uganda AIDS Commission   |
| <b>UCAEM</b>   | Uganda Coalition for Access to Essential Medicines                 |
| <b>UDHR</b>    | Universal Declaration of Human Rights                              |
| <b>UDN</b>     | Uganda Debt Network  |
| <b>UHRC</b>    | Uganda Human Rights Commission                                     |
| <b>UNAIDS</b>  | Joint United Nations Programme on HIV/AIDS                         |
| <b>UNASO</b>   | Uganda Network of AIDS Service organisations                       |
| <b>UNDP</b>    | United Nations Development Programme                               |
| <b>UPDF</b>    | Uganda People's Defence Force                                      |
| <b>VCT</b>     | Voluntary counselling and testing services                         |
| <b>WB</b>      | World Bank   |
| <b>WHO</b>     | World Health Organisation  |
| <b>WTO</b>     | World Trade Organisation   |

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# CHAPTER ONE

## INTRODUCTION

### 1.1 BACKGROUND OF THE STUDY

HIV/AIDS epidemic in Uganda has claimed over one million lives in two decades<sup>1</sup> and continues to be the country's main cause of death amongst adults.<sup>2</sup> According to the 2005 HIV/AIDS Sero-Behavioural Survey, approximately 800,000 people are living with HIV/AIDS in Uganda.<sup>3</sup> This Survey reveals that an estimated 7 percent of Uganda's adult population is living with HIV/AIDS, up from previous average estimate of 4.1 percent.<sup>4</sup> All these adults are between the ages of 15-49 years, the most economically productive age group and often fenders of families.<sup>5</sup> In addition, at the end of 2003, about 84,000 children were living with HIV/AIDS in Uganda, and the number of AIDS orphans amounted to 940, 000.<sup>6</sup>

Although the number of new infections has dramatically decreased during the last ten years, portraying this country as the "AIDS miracle", the number of people already infected and progressing to AIDS is increasing.<sup>7</sup> Access to anti-retroviral (ARV) drugs, as well as to medicines for treatment of opportunistic infections (TOI), is essential for people living with HIV/AIDS (PLWHA) to enjoy their right to life<sup>8</sup> and to health.<sup>9</sup> Although access to these essential medicines forms part of the core content of the right to health, which states should be able to provide irrespective of their available resources,<sup>10</sup> slightly more than half of the people in need in Uganda were accessing them in June 2005.<sup>11</sup>

Of 63,896 PLWHA accessing ARVs, still 83.5 percent are paying the medicines out of their pockets.<sup>12</sup> This is despite the fact that Uganda receives funds from various sources, among which Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) and the US President's Emergency Plan for AIDS Relief

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<sup>1</sup> Uganda AIDS Commission (UAC) "HIV/AIDS in Uganda: The HIV/AIDS epidemic" <<http://www.aidsuganda.org/aids/index.htm>>(accessed 28-8-2005).

<sup>2</sup> Joint UN Programme on HIV/AIDS (UNAIDS) Uganda <<http://www.unaids.org/en/geographical+area/by+country/uganda.asp>>(accessed 28-8-2005).

<sup>3</sup> Plusnews "UGANDA: Adult HIV infections rise to seven percent" (5-5-2005) <[http://www.plusnews.org/AIDSreport.asp?ReportID=4763&SelectRegion=East\\_Africa&SelectCountry=UGANDA](http://www.plusnews.org/AIDSreport.asp?ReportID=4763&SelectRegion=East_Africa&SelectCountry=UGANDA)> (accessed 30-8-2005).

<sup>4</sup> World Health Organisation (WHO) "Uganda-Summary country profile for HIV/AIDS treatment scale-up" (2005) 1 <[http://www.who.int/3by5/june2005\\_uga.pdf](http://www.who.int/3by5/june2005_uga.pdf)>(accessed 15-8-2005). Ministry of Health (MoH) officials attributed the difference to the methods used to collect data. This latest survey was based on a nationwide sample of people who voluntarily gave their blood to be tested for the virus, whereas previous data was based on records from hospitals and antenatal clinics (ANC). Plusnews, as above.

<sup>5</sup> UAC "The HIV/AIDS and impact" (2002).

<sup>6</sup> UNAIDS/WHO "Epidemiological Fact sheet on HIV/AIDS and sexual transmitted diseases in Uganda" (2004) 3.

<sup>7</sup> F Okero *et al* (WHO) "Scaling up anti-retroviral therapy: Experiences in Uganda-Case study" (2003) *Perspectives and practice in anti-retroviral treatment* 6.

<sup>8</sup> Human Rights Committee (HRC) General Comment (GC) 6: "The right to life" (1982) para.5.

<sup>9</sup> Committee of Social, Economic and Social Rights (CESCR) GC 14: "The right to the highest attainable standard of health" (2000) UN.Doc.E/C12 2000/4.

<sup>10</sup> As above.

<sup>11</sup> 63,896 out of 114,000 people, WHO (above n.4).

<sup>12</sup> As above.

(PEPFAR).<sup>13</sup> Although the cost of ARV treatment (ART) in Uganda has dramatically decreased since 1997, the price of treatment remains still unaffordable for most Ugandans.<sup>14</sup>

## 1.2 STATEMENT OF THE PROBLEM

This study looks at this reality from a human rights (HR) approach, identifying right-holders and duty-bearers with regard to access to essential treatment for PLWHA. The state of Uganda, as well as other relevant stakeholders, is bound by various HR instruments at international level, which impose on them various obligations with regard to access to essential treatment. From this perspective, the study aims at determining the extent to which these obligations have been met at national level, and the obstacles that impede the government, and other relevant non-state actors, discharging their obligations with regard to this right. The study then provides various recommendations to the different stakeholders in order to fully realise the right at stake.

## 1.3 WORKING DEFINITION

For the purpose of this study, access to essential treatment for PLWHA is understood as access to those ARVs, and those drugs essential for TOI, which are included in the WHO Essential Medicines List (EML).<sup>15</sup> Access to these drugs implies that they should be provided in sufficient quantity by trained personnel, respectful of cultural and ethical issues.<sup>16</sup> They should be geographically accessible and economically affordable to everyone without discrimination and should follow standards of quality.<sup>17</sup>

## 1.4 SCOPE OF THE STUDY

This study focuses on the right of PLWHA to access essential treatment in Uganda. It analyses this right within the spectrum of international HR instruments of relevance for Uganda, as well as the guidance provided by the different international HR monitoring bodies. It then looks at the compendium of national legislation, policy and jurisprudence that delimitate the scope of this right at national level. It finally examines the interaction of the market forces in the realisation of this right, as well as the political and socio-economic factors that hinder access at national level.

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<sup>13</sup> As above. GF has recently decided to freeze the funds granted to Uganda because of the findings of an auditor's report pointing to "serious mismanagement" by the MoH. "Global Fund suspends grants to Uganda" <[http://www.theglobalfund.org/en/media\\_center/press/pr\\_050824.asp](http://www.theglobalfund.org/en/media_center/press/pr_050824.asp)>(accessed 1-9-2005).

<sup>14</sup> D Oveti (*3D-Trade-Human Rights-Equitable Economy*) "Implementation of the Covenant on Civil and Political Rights in Uganda: Trade-related intellectual property rights, access to HIV/AIDS medicines and the fulfilment of civil and political rights" (2004).

<sup>15</sup> <[http://www.who.int/medicines/organization/par/edl/expcom14/EML14\\_en.doc](http://www.who.int/medicines/organization/par/edl/expcom14/EML14_en.doc)>(accessed 17-8-2005).

<sup>16</sup> GC 14 (above n.9) para.12.

<sup>17</sup> As above.

The present dissertation is an abbreviated version of the research carried out. A full version of the study is available on request.

## **1.5 OBJECTIVES**

The overall objective of this study is to determine how access to essential treatment for PLWHA in Uganda can be realised using a HR-approach. The specific objectives of this study are the following:

- (i) Determine the scope of the obligations derived from the right to access essential treatment for state and non-state actors;
- (ii) Examine the particular needs of PLWHA in Uganda in terms of access to essential treatment;
- (iii) Assess the role played by the different stakeholders in Uganda, both state and non-state actors, in the realisation of the right of PLWHA to access essential treatment;
- (iv) Examine the obstacles that impede the realisation of this right to PLWHA in Uganda;
- (v) Provide recommendations to the relevant stakeholders regarding the different lines of action and their adequacy for the realisation of this right.

## **1.6 RESEARCH QUESTIONS**

The study attempts to answer the following research questions:

- (i) Is there a right to access essential treatment for PLWHA and what does it entail?
- (ii) To what extent does the definition of this right at international level play a role in its realisation in Uganda?
- (iii) Have state and non-state actors discharged their international obligations at national level?
- (iv) What are the obstacles impeding the realisation of this right in Uganda?
- (v) How can the action taken by the relevant stakeholders be improved?

## **1.7 OVERVIEW OF RELATED LITERATURE**

There is a dearth in the literature on access to essential treatment in Uganda from a HR perspective. Wandira<sup>18</sup> deals with the subject from a socio-legal point of view, mentioning the potential rights

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<sup>18</sup> A Wandira "The legal aspects and practice relating to the access to and use of antiretroviral drugs in Uganda", (2005) LLM dissertation Makerere University, Kampala.

affected by access to ARVs but discouraging any HR-approach to the problem.<sup>19</sup> Moreover, the author limits the scope of her research to the governmental response to access to ARVs, without looking into the role played by the judiciary and other non-state actors. Similarly, Richey and Haakonsson deal with ARVs taking Uganda as an example, without adopting a HR-approach.<sup>20</sup> Muwanguzi<sup>21</sup> adopts a much broader approach and looks into all the HR affected by HIV/AIDS. Although he provides an overview of judicial activism with regard to the HR affected, his study does not draw conclusions from other jurisdictions. Nakadama<sup>22</sup> provides some recommendations regarding treatment of HIV/AIDS in Ugandan prisons, without dealing with the status of the situation as such and acknowledging the lack of statistics available. Muganda<sup>23</sup> deals superficially with HIV/AIDS, among other contagious diseases in Uganda. On the local level, therefore, I have not come across literature that discusses the subject deeply from a HR perspective, looking into how to render this right justiciable.

As regards those authors that have dealt with access to essential treatment for PLWHA from a South African (SA) perspective, it is worth mentioning Chirwa,<sup>24</sup> who does not, however, dwell too much into the justiciability of the right, or De Vos,<sup>25</sup> Baimu,<sup>26</sup> Klug,<sup>27</sup> and Berger,<sup>28</sup> who undertake an analysis from the point of view of the SA jurisprudence.

HIV/AIDS from a HR perspective has been dealt with by recognised scholars such as Mann,<sup>29</sup> Gruskin and Tarantola<sup>30</sup> or Cook.<sup>31</sup> The link between health and HR has also been explored by Gostin,<sup>32</sup> Tomasevski<sup>33</sup>, or Toebees,<sup>34</sup> who explore the obligations of the state to respect, protect and fulfil the

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<sup>19</sup> The author concludes that the right to essential treatment is not justiciable, and the international HR instruments binding on Uganda are not enforceable.

<sup>20</sup> L Richey, S Haakonsson (Denmark Institute of International Studies-DIIS) "Access to ARVs: Aid, trade and governance in Uganda" (2004) DIIS Working paper 2004/19.

<sup>21</sup> G Muwanguzi "HIV/AIDS and human rights: An assessment of compliance with international guidelines in the legal sector in Uganda", (2002) LLM dissertation Makerere University, Kampala.

<sup>22</sup> E Nakadama "The right to health of prisoners in Uganda" (2001) LLB dissertation, Makerere University, Kampala.

<sup>23</sup> C Muganda "The right to medical care in Uganda: a socio-legal analysis" (2002) LLB dissertation, Makerere University, Kampala.

<sup>24</sup> D Chirwa "The right to health in International Law: Its implications for the obligations of State and non-state actors in ensuring access to essential medicines" (2003) 19(4) *South African Journal on Human Rights (SAJHR)* 541.

<sup>25</sup> P De Vos "So much to do, so little done: The right of access to anti-retroviral drugs post-Grootboom" (2003) 7 *Law, Democracy and Development* 83.

<sup>26</sup> E Baimu "The government's obligation to provide anti-retrovirals to HIV-positive pregnant women in an African human rights context: The South African Nevirapine case" (2002) 2 *African Human Rights Law Journal* 160.

<sup>27</sup> H Klug "Access to healthcare: judging implementation in the context of AIDS" (2002) 18(1) *SAJHR* 114.

<sup>28</sup> J Berger "Litigation strategies to gain access to treatment for HIV/AIDS: the case of South Africa's Treatment Action Campaign" (2002) 20 *Wisconsin International Law Journal* 595.

<sup>29</sup> J Mann, "Human rights and AIDS: the future of the pandemic" (1996) 30 *John Marshall Law Review* 195.

<sup>30</sup> S Gruskin, D Tarantola "Human rights and HIV/AIDS" (2002) *HIV InSite Knowledge Base Chapter* <<http://hivinsite.ucsf.edu/InSite?page=kb-08-01-07>>(accessed 15-8-2005).

<sup>31</sup> R Cook *et al*, *Reproductive health and human rights, integrating medicine, ethics and law* (2003).

<sup>32</sup> L Gostin "Public health, ethics, and human rights: a tribute to the late Jonathan Mann" (2001) 29 *Journal of Law, Medicine and Ethics* 121.

<sup>33</sup> K Tomaševski "Health Rights" in A Eide *et al* *Economic, Social and Cultural Rights: A Textbook* (1995).

<sup>34</sup> B Toebees "The Right to Health" in A Eide *et al* (eds) *Economic, Social and Cultural Rights: A Textbook* (2001).

right to health. Chapman and Russell, develop the concept of “core content” of this right,<sup>35</sup> whereas Twinomugisha<sup>36</sup> and Kiapi,<sup>37</sup> analyse this right in the Ugandan context.

There is substantial literature on the right to health as a socio-economic right. The scholars are divided into those that consider the right to health as costly-driven, programmatic and therefore, not justiciable, such as Bossuyt<sup>38</sup> or Vierdag,<sup>39</sup> and those that consider all HR as interdependent and justiciable, either from a Ugandan perspective, such as Oloka-Onyango,<sup>40</sup> South African, such as Brand;<sup>41</sup> or international, such as Viljoen,<sup>42</sup> Robertson,<sup>43</sup> An-Na'im,<sup>44</sup> or Hunt.<sup>45</sup> The role of Ugandan courts in enforcing HR has been tackled by Tibatemwa-Ekirikubinza,<sup>46</sup> Onoria,<sup>47</sup> or Mukudi Malubiri<sup>48</sup> among many others.

Finally, the link between globalisation and access to drugs is dealt with by various authors, among which Correa,<sup>49</sup> Rovira<sup>50</sup> or Vawda.<sup>51</sup>

## 1.8 RELEVANCE OF THE STUDY

The following study attempts at providing a HR response to the existent problems regarding access to essential treatment for PLWHA in Uganda. In view of the scarcity of the literature in the subject, this study tries to bring some thoughts as to the possible solutions foreseen from this angle.

Particular questions of deprivation, such as poverty, or inadequate access to ARVs, are often attributed to forces over which the state has no control, such as the impact of globalisation, or the

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<sup>35</sup> A Chapman, S Russell (eds) *Core obligations: building a framework for economic, social and cultural rights* (2002).

<sup>36</sup> B Twinomugisha “Barriers to the protection of rural women’s right to maternal healthcare in Uganda” 11(1) (2005) *East African Journal of Peace & Human Rights (EAJPHR)* 67.

<sup>37</sup> S Kiapi “Interpreting the right to health under the African charter” 11 (2005) *EAJPHR* 1, 1.

<sup>38</sup> M Bossuyt “Non-discrimination as enshrined in art.2, para.2, of the International Covenant on Economic, Social and Cultural Rights” (2005) UN.Doc.E/CN.4/Sub.2/2005/19.

<sup>39</sup> E Vierdag “The legal nature of the rights granted by International Covenant on Economic, Social and Cultural Rights”, (1978) *Netherlands Yearbook of International Law* 69, cited by Bossuyt, as above.

<sup>40</sup> J Oloka-Onyango “Economic and social human rights in the aftermath of Uganda’s Fourth Constitution: A critical Reconceptualisation” (2005) *Centre for Basic Research Working Paper No.88/2004*.

<sup>41</sup> D Brand “The ‘politics of need interpretation’ and the adjudication of socio-economic rights claims in South Africa” (2005) (unpublished).

<sup>42</sup> F Viljoen “The justiciability of socio-economic and cultural rights: experience and problems” (2005) (unpublished).

<sup>43</sup> B Robertson “Social, economic and cultural rights: time for a reappraisal” (1997) *New Zealand Business Roundtable*.

<sup>44</sup> A An-Na'im “To affirm the full human rights standing of economic, social & cultural rights” in Y Ghai *et al*, *Economic, social & cultural rights in practice* (2004) 9.

<sup>45</sup> P Hunt *Reclaiming social rights-international and comparative perspectives* (1996).

<sup>46</sup> L Tibatemwa-Ekirikubinza “The judiciary and enforcement of human rights: Between judicial activism and judicial restraint” (2002) 8(2) *EAJPHR* 145.

<sup>47</sup> H Onoria “Review of major decisions on fundamental rights and freedoms in Uganda in 2001 and 2002” (2003) 9(2) *EAJPHR* 332.

<sup>48</sup> P Mukudi Walubiri (ed) *Uganda: Constitutionalism at crossroads* (1998).

<sup>49</sup> C Correa “Implementation of the WTO General Council Decision on paragraph 6 of the Doha Declaration on the TRIPS agreement and public health” (2004) 5.

<sup>50</sup> J Rovira “Trade agreements, intellectual property, and the role of the World Bank in improving access to medicines in developing countries” (2004) *Yale Journal of Health Policy, Law, and Ethics*.

<sup>51</sup> Y Vawda “From Doha to Cancun: The quest to increase access to medicines under the WTO rules” (2003) 19 *SAJHR* 679.



general lack of resources of a particular country.<sup>52</sup> These deprivations are taken away from the political contestation and their eradication is considered more as an aspiration rather than an entitlement of every human being, particularly for those vulnerable groups suffering the deprivation. The HR-approach challenges this depoliticisation, raises awareness and empowers those affected with the means to claim accountability from those bound to discharge their duties. This approach proves particularly relevant in Uganda, where issues like poverty diminish the capability of vulnerable groups to react against violations of the core content of their rights.

## **1.9 OUTLINE OF THE CHAPTERS**

This study comprises five chapters. The present chapter exposes the problem, the objectives of the study and the research questions, reviews the literature available on the subject, outlines the study's structure, proposes a methodology and points out to the study's limitations and relevance.

Chapter two sets out the international legal framework of the study. It outlines the scope of the right of PLWHA to access to essential treatment under different international instruments of relevance for Uganda and its connection with other HR. The chapter also assesses the implications of this right for state and non-state actors.

Chapter three sets out the national legal, policy and judicial framework. It explores the action taken by the various branches of the government in addressing the international obligations with regard to access essential treatment. This chapter will also look at the role played by other relevant stakeholders in the realisation of this right in Uganda.

Chapter four analyses the various obstacles that impede the realisation of this right at national level, taking into account the globalisation process, the political situation of Uganda, as well as other socio-economic factors.

Chapter five provides the final conclusions and recommends legal, judicial and administrative channels towards the realisation of the right to access essential treatment for PLWHA in Uganda.

## **1.10 RESEARCH METHODOLOGY**

The analysis of this topic will be carried out following two types of methods:

(i) *Non-Empirical*: The major part of the analysis will be conducted through library and desk research, reviewing the literature, international instruments and case-law available regarding access to essential treatment for PLWHA. The legislation and policies existent in Uganda, as well as the

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<sup>52</sup> Brand (above n.41) 4.

case-law dealing with socio-economic rights will also be looked at. Sources of secondary data include various libraries (official and private) and the Internet.

(ii) *Empirical*: Qualitative methods of research will also be used to assess the problems on the ground related to access to essential treatment in Uganda. Although cognisant of the importance of interviewing PLHWA in order to obtain information from primary sources, this study will rather choose key informants from the major non-governmental organisations (NGOs) in Uganda dealing with access to essential treatment, and, when possible, from medical centres as well as key policy makers. This qualitative method is considered to be more suitable, bearing in mind the broad spectrum of the informants and recognising the time implications of conducting a quantitative exercise.

### **1.11 LIMITATIONS**

Although cognisant of the fact that the study of the realisation of access to essential treatment requires a multi-disciplinary approach, this dissertation will focus on access to essential treatment from a HR perspective. Ideally, all aspects regarding HIV/AIDS and HR should be looked at, due to their interrelation and interdependence, but, for the purpose of this study, I will only focus on the right of PLWHA to access to essential treatment in Uganda.

## CHAPTER TWO

### SCOPE OF ACCESS TO ESSENTIAL TREATMENT FOR PLWHA UNDER INTERNATIONAL LAW

#### 2.1. INTRODUCTION

The following chapter outlines the scope of access to essential treatment for PLWHA under the HR law applicable to Uganda, with a view to illustrate that PLWHA have a right to access such a treatment. Because of the absence of a specific provision in the 1995 Ugandan Constitution recognising the right to health,<sup>53</sup> this delimitation is particularly relevant in this study. It will help to establish the obligations that Uganda undertook at international level and the implications that these international obligations have at national level.

The objective of this chapter is twofold: first, to place the debate of access to essential treatment for PLWHA in the HR arena, identifying the right-holders and the duty-bearers of this right according to HR law; and secondly, to set out the international standards against which the action of the different actors involved in the realisation of this right in Uganda is to be assessed, with a view to determine their compliance with their international obligations.

#### 2.2. HR RESPONSE TO HIV/AIDS AND ACCESS TO TREATMENT

This study analyses access to essential treatment of PLWHA in Uganda from a HR perspective. A rights-related approach proves particularly useful with regard to HIV/AIDS, where many societal factors, such as poverty or gender inequality, are determinant in people's vulnerability to the pandemic,<sup>54</sup> and cannot, therefore, be tackled through traditional public health programmes.<sup>55</sup> Vulnerability to HIV is further increased when the disadvantaged groups are denied their rights.<sup>56</sup> Therefore, a HR-approach to HIV/AIDS is essential to empower PLWHA to respond to the pandemic, enabling them to improve their quality of life.<sup>57</sup>

A rights-related approach, "brings into focus the relationship between the state—the first-line provider and protector of HR—and individuals who hold their HR simply for being human."<sup>58</sup> It provides the

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<sup>53</sup> The only references to health issues in the Constitution are found in Objectives XX and XIV of the National Objectives and Directive Principles of State Policy (NODPSP). See below, chap.3.

<sup>54</sup> Gruskin, Tarantola (above n.30).

<sup>55</sup> Mann (above n.29).

<sup>56</sup> Gruskin, Tarantola (above n.30).

<sup>57</sup> S Gruskin, *et al* "HIV/AIDS and human rights in a nutshell" (2004) 4.

<sup>58</sup> D Tarantola "Building on the synergy between health and human rights: A global perspective" <[http://www.hsph.harvard.edu/xfbcenter/FXBC\\_WP8--Tarantola.pdf](http://www.hsph.harvard.edu/xfbcenter/FXBC_WP8--Tarantola.pdf)>(accessed 16-8-2005).

means through which individuals can legitimately assert their entitlements and require the government to observe those international standards to which it has committed itself.<sup>59</sup>

However, this approach is not free of criticism. Among the most common critics, as summarised by Robinson stand those that believe that HR use “adversarial and judgmental techniques to monitor state performance”, and “diminish the notion of national sovereignty” by referring to international standards. These techniques reduce ultimately the willingness of governments to cooperate.<sup>60</sup>

To these critics several points are worth mentioning: First, a HR-approach is not necessarily adversarial, since it can also help governments to design more efficient policies that take into account societal factors.<sup>61</sup> Secondly, this approach does not diminish the notion of sovereignty but utilises it, by reminding states that they should abide by the international obligations that they have voluntarily undertaken, exercising their national sovereignty. Finally, the notion of responsibility used under the rights-related approach is broadening to cover non-state actors as well,<sup>62</sup> bearing in mind the determinant role played by many stakeholders in the realisation of rights.

### **2.3. THE RIGHT TO ACCESS ESSENTIAL TREATMENT AS PART AND PARCEL OF THE RIGHT TO HEALTH**

#### **2.3.1. The right to health within the framework of social, economic, and cultural rights**

Since its codification in the International Covenant of Economic, Social and Cultural Rights (ICESCR) in 1966,<sup>63</sup> the right to health has been considered separate from those rights codified in the International Covenant of Civil and Political Rights (ICCPR). Although this separation responded to the political momentum in which these rights were codified,<sup>64</sup> some authors justified this distinction on the grounds that socio-economic rights impose “positive” obligations that require state intervention,<sup>65</sup> they need substantial spending for their implementation, and “judges lack two essential qualifications: expertise and political accountability” for adjudicating upon them.<sup>66</sup> Moreover, the terms of these rights are imprecise to guide judges as to their content.<sup>67</sup> Unfortunately, these arguments gained

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<sup>59</sup> Cook *et al* (above n.31).

<sup>60</sup> M Robinson “Realizing rights: challenges for the international forum for development” 55 <<http://www.ssrc.org/programs/ifd/publications/DevImperative/Robinson.pdf>>(accessed 16-8-2005).

<sup>61</sup> As above.

<sup>62</sup> As above.

<sup>63</sup> Art.12 ICESCR, ratified by Uganda in 1987. Information on the UN HR instruments ratified by Uganda in <[http://www.bayefsky.com/html/uganda\\_t1\\_ratifications.php](http://www.bayefsky.com/html/uganda_t1_ratifications.php)>(accessed 17-8-2005).

<sup>64</sup> Western countries favoured the exclusion of socio-economic rights and socialist countries their inclusion. Bossuyt (above n.38).

<sup>65</sup> Bossuyt (as above) para.10 or Vierdag, cited in Eide *et al* “Economic, social and cultural Rights: A universal challenge”, in Eide *et al* (above n.33) 4-5.

<sup>66</sup> As summarised by Hunt (above n.45).

<sup>67</sup> Robertson (above n.43).

support in many jurisdictions, like Uganda, which converted various socio-economic rights into programmatic aspirations within its Constitution.<sup>68</sup>

Today the idea that all rights are interrelated is growing faster since its recognition in the Vienna Declaration.<sup>69</sup> The interdependence of all the rights can be clearly exemplified by the right to access essential treatment. When PLWHA are denied access their right to life is clearly at stake. The justiciability of this right has been largely demonstrated in various jurisdictions.<sup>70</sup> Moreover, this right cannot be considered to be vague, since its content has been recently spelled out by the CESCR, among other international bodies.

However, part of the arguments distinguishing between generations of rights was founded on the International Covenants themselves. Under the ICESCR, the states parties' obligation is not immediate, as it is under the ICCPR, but explicitly progressive and subject to the availability of resources. This was a "necessary flexibility device",<sup>71</sup> bearing in mind the reality of many countries, but soon it became "an escape hatch (for) recalcitrant states".<sup>72</sup> In order to avoid this perverse result, the CESCR clarified that the Covenant imposed various obligations: some are immediate, such as the principle of non-discrimination; others belong to the minimum core content of each right, which every state must satisfy, whatever their stage of economic development; and others vary from one state to another - and over time in relation to the same state- depending on the available resources (the "variable dimension").<sup>73</sup>

### **2.3.2. The right to access essential treatment as part of the core content of the right to health under the ICESCR**

The CESCR has spelled out these various obligations within the right to health in its GC 14. Access to essential treatment can be clearly identified as a minimum core obligation in the duty "to provide essential drugs, as from time to time defined by WHO's Action Programme on Essential Drugs". However, it is also implicit in the core obligations to ensure maternal and child healthcare, access to health facilities, and to take measures to prevent and treat epidemic diseases.<sup>74</sup> According to

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<sup>68</sup> These arguments were raised by various parliamentarians during the constitutional process. Oloka-Onyango (above n.40).

<sup>69</sup> World Conference on Human Rights (1993) UN.Doc.A/CONF.157/23, para.5.

<sup>70</sup> Eg *Cruz Bermudez et al v Ministerio de Sanidad y Asistencia Social*, Case No.15.789, Decision No.91615 (1999).

<sup>71</sup> GC 3: "The nature of States parties obligations" (1990), UN.Doc.E/1991/23 para.9.

<sup>72</sup> S Leckie, "Another step towards indivisibility: identifying the key features of violations of economic, social and cultural rights" (1998) 20(1) *Human Rights Quarterly* (HRQ) 81, 94.

<sup>73</sup> GC 3 (above n.71).

<sup>74</sup> GC 14 (above n.9) para.43.

CESCR, state parties cannot, under any circumstances whatsoever (including financial constraints), justify its non-compliance with the core obligations, “which are non-derogable”.<sup>75</sup>

Commenting on the core obligations, Chapman argues that GC 14 does not mandate the universal availability of specific items.<sup>76</sup> She bases herself on the language used in these obligations, which sometimes is left unspecified. However, I do not share her opinion, in particular with regard to the obligation to provide essential drugs. I believe this core obligation is as specific as it can be, bearing in mind that it should be susceptible of being applicable by any state at any point in time. Moreover, this core obligation is qualified by the requirements of availability, accessibility, acceptability and quality.<sup>77</sup> In addition, I believe the delimitation of minimum essential levels of the right to health is a crucial starting point to render this right tangible and enforceable vis-à-vis those recalcitrant states that put forward the alleged “programmatically” nature of this right to avoid compliance. Thus, I do not share the view that defining these levels requires “thinking small”, as Chapman puts it, but rather thinking in accountability terms.

Chapman also questions whether these minimum core obligations are reasonable vis-à-vis the poorest countries. Kiapi agrees and purports that there is a need for country-specific core contents.<sup>78</sup> I argue in this paper, however, that implementing the minimum core content is more a question of prioritisation of expenditure,<sup>79</sup> well-managed healthcare strategies, and political will, rather than a question of resources. Moreover, states have the obligation to seek international assistance, if necessary, to meet these obligations.<sup>80</sup> Those who advocate for a country-based minimum core content seem to identify the core content of the right to health with its variable dimension, and therefore, deprive the concept of “core content” of its real meaning, that is, the essence of the right at stake, which should be universal, and non-derogable, as indicated by the CESCR.

### **2.3.3. The right to health as interpreted in other HR instruments**

The Universal Declaration of HR (UDHR), today considered by some scholars as part of international customary law<sup>81</sup> and therefore binding on all states, recognised the right to health not only as a right to healthcare but also to the underlying determinants of health, such as food or social services.<sup>82</sup>

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<sup>75</sup> As above, para.47. However, the CESCR may take into account the possible lack of resources if the country demonstrates that every effort has been made to use all available resources in an effort to satisfy, as a matter of priority, those minimum obligations.

<sup>76</sup> Chapman (above n.35).

<sup>77</sup> Above, sec.1.3.

<sup>78</sup> Kiapi (above n.37) 6.

<sup>79</sup> Chirwa (above n.24).

<sup>80</sup> GC 3 (above n.71).

<sup>81</sup> Weston and Marks, cited by Gostin (above n.32).

<sup>82</sup> (1948) UN.Doc.A/810, art.25(1).

The right of women not to be discriminated against with regard to access to healthcare has also been recognised in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW),<sup>83</sup> ratified by Uganda in 1985. The Committee on CEDAW imposed on the states the obligation to ensure timely, affordable, and acceptable access to healthcare.<sup>84</sup> In addition, the Committee has frequently inquired on HIV/AIDS issues when analysing country reports, for example with regard to Uganda.<sup>85</sup>

The Convention of the Rights of the Child (CRC), ratified by Uganda in 1990, also protects the right to health of children.<sup>86</sup> According to the Committee on CRC, states should provide ARVs to pregnant women and their partners, as well as children, on the basis of non-discrimination.<sup>87</sup> In addition, states parties must ensure the incorporation of HIV/AIDS and child rights issues in programmes dealing with children victims of abuse.<sup>88</sup>

The right to health is also recognised in the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), ratified by Uganda in 1980.<sup>89</sup> The Committee on the Elimination of All Forms of Racial Discrimination (CERD) expressed its concerns with regard to the rapid spread of HIV/AIDS among marginalised groups, particularly women, when analysing Uganda's latest report.<sup>90</sup>

At regional level, the African Charter on Human and Peoples' Rights (ACHPR),<sup>91</sup> ratified by Uganda in 1986,<sup>92</sup> protects the right to health in its article 16. The ACHPR provides an adequate forum for the enforcement of this right, since it does not limit its realisation in any sense<sup>93</sup> and recognises the interdependence of all HR.<sup>94</sup> Moreover, the African Commission of Human and Peoples' Rights (African Commission) can draw inspiration from various sources of international law when deciding on complaints.<sup>95</sup> The Commission already stressed the difficulties that PLWHA face in accessing treatment as one of the major obstacles in realising their right to health.<sup>96</sup> Furthermore, in *Free Legal*

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<sup>83</sup> (1979) UN Doc. A/34/36. Art.11(1)(f), 12, 14(2)(b).

<sup>84</sup> General Recommendation (GR) 24: "Art.12: Women and Health", (1999) UN.Doc.A/54//38 paras.21-22.

<sup>85</sup> The Committee shown concern on the drastic cuts in the health budget and the pervasive effect of customary family law (ex. polygamy) on the spread of the pandemic (2002) UN.Doc.CEDAW/C/SR.576.

<sup>86</sup> (1989) UN.Doc.A/44/49, art.6, 24.

<sup>87</sup> GC 3 "HIV/AIDS and the rights of the child" (2003) UN.Doc.CRC/GC/2003/1, para.23.

<sup>88</sup> As above, para.34.

<sup>89</sup> (1965) GA.Res 2106 (XX), art.5.

<sup>90</sup> (2003) UN.Doc.A/58/18 para.280.

<sup>91</sup> (1982) OAU.Doc.CAB/LEG/67/3/Rev 5.

<sup>92</sup> <[http://www.achpr.org/english/\\_doc\\_target/documentation.html?..ratifications/ratification\\_charter\\_en.pdf](http://www.achpr.org/english/_doc_target/documentation.html?..ratifications/ratification_charter_en.pdf)>(accessed 23-8-2005).

<sup>93</sup> A Odinkalu "Implementing Economic, Social and Cultural Rights under the African Charter", in M Shaw *et al* (eds) *The African Charter of Human and People's Rights: The system in practice* (2002).

<sup>94</sup> Art.8 ACHPR.

<sup>95</sup> Art.60 ACHPR.

<sup>96</sup> (2001) Final communiqué of the 29<sup>th</sup> ordinary session, para.7.

*Assistance Group and others v Zaire*, the African Commission held that a shortage of medicines constituted a violation of article 16.<sup>97</sup>

The African Charter on the Rights and Welfare of the Child (ACRWC), ratified by Uganda in 1994, emphasises the right to access primary healthcare (PHC).<sup>98</sup>

With the establishment of the African Court on Human and Peoples' Rights, the protection of the right to health could be enforced through binding judgements.<sup>99</sup> Moreover, since the jurisdictional scope of the Court will also encompass other HR instruments ratified by the country,<sup>100</sup> it could become a complaint mechanism for those HR instruments that do not have it, such as the ICESCR or the CRC.

#### **2.4. THE RIGHT TO ACCESS ESSENTIAL TREATMENT AND ITS RELATIONSHIP WITH OTHER HR**

As indicated above, the right to access to essential treatment is essential for the enjoyment of many other rights, such as the right to life.<sup>101</sup> The HRC has indicated that, in protecting human life,<sup>102</sup> states are obliged to undertake measures to eliminate epidemics, to reduce infant mortality and to increase life expectancy.<sup>103</sup> Access to essential treatment is also crucial for PLWHA to enjoy their right to an adequate standard of living<sup>104</sup> and to physical integrity.<sup>105</sup> To that extent, the withdrawal of essential treatment, in cases where someone is suffering, can amount to inhuman treatment,<sup>106</sup> and so does non-consensual experimentation with new drugs.<sup>107</sup>

The right to freedom from discrimination<sup>108</sup> is implicit in the concept of access to essential treatment, which has been defined above as access to drugs geographically and economically accessible to everyone without discrimination. Moreover, PLWHA have a right to be informed<sup>109</sup> of the availability of essential treatment and the benefits and risks of the different drugs they may take in order to make well-informed choices, either before participating in research projects or in their day-to-day life.<sup>110</sup> The

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<sup>97</sup> (2000) AHRLR 74 (ACHPR 1995).

<sup>98</sup> (1990) OAU.Doc.CAB/LEG/24.9/49.

<sup>99</sup> The Protocol to the African Charter on the Establishment of an African Court became into force in 2004, but the Court is not yet operational. Uganda ratified the Protocol in 2001.

<sup>100</sup> Art.3, 7.

<sup>101</sup> De Vos (above n.25), S Marks "Jonathan Mann's legacy to the 21st century: the human rights imperative for public health" (2001) 29 *Journal of Law, Medicine and Ethics* 131.

<sup>102</sup> Art.6 ICCPR, ratified by Uganda, together with its Optional Protocol 1, in 1995.

<sup>103</sup> GC 6 (above n.8).

<sup>104</sup> Eg. art.11(1) ICESCR.

<sup>105</sup> Eg. 5 ACHPR.

<sup>106</sup> *Case D v UK* (1997), 24 EHRR 423.

<sup>107</sup> HRC, GC 20 "Replaces GC 7 concerning prohibition of torture and cruel treatment or punishment" (1992) para.7.

<sup>108</sup> Eg. art.26 ICCPR.

<sup>109</sup> Eg. art.9(1) ACHPR.

<sup>110</sup> *LCB v UK* (1998) 27 EHRR 212, para.36.



fulfilment of the right to HIV/AIDS-related education<sup>111</sup> is also crucial for PLWHA to be able to follow the treatment in an effective manner.

PLWHA should have the right to benefit from the latest advancements regarding essential treatment,<sup>112</sup> while respecting the minimum guarantees established in article 15(1)(c) ICESCR regarding the right of the author to benefit from the protection of the interests of its production. Access to essential treatment requires prior HIV-testing, which should be voluntary and confidential, as well as prior and post confidential HIV-counselling, in order to protect the right to dignity, and privacy of PLWHA.<sup>113</sup> According to the Committee on CRC, the accessibility of voluntary, confidential HIV-counselling and testing (VCT), with due attention to the evolving capacities of children, is fundamental to their rights,<sup>114</sup> particularly for children sexually exploited.<sup>115</sup>

The CESCR has specifically recognised the right of victims of violations of the right to health to have access to effective judicial or other appropriate remedies,<sup>116</sup> which should be accessible, affordable, timely and effective,<sup>117</sup> and provide for adequate reparation. Neglect by the courts of the responsibility to ensure that the state's conduct is consistent with its obligations under the international HR instruments is incompatible with the principle of the rule of law.<sup>118</sup> Moreover, it contradicts the general principle of law of reparation for breach of an undertaking.<sup>119</sup>

## **2.5. IMPLICATIONS OF THE RIGHT TO ACCESS ESSENTIAL TREATMENT FOR STATE AND NON-STATE ACTORS**

### **2.5.1. IMPLICATIONS FOR THE STATE**

Through ratification or adherence to the international instruments mentioned above, Uganda has undertaken the duty to give effect in its territory to the international HR obligations specified in those instruments.<sup>120</sup> The state has a liberty of means to give effect to that duty, but whatever means it chooses, they must be adequate to ensure fulfilment of the rights recognised in those treaties.<sup>121</sup>

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<sup>111</sup> Eg. art.12(2)(c) ICESCR.

<sup>112</sup> Art. 15(1)(b) ICESCR.

<sup>113</sup> Eg art.10(1), 17 ICCPR.

<sup>114</sup> GC 3 (above n.87).

<sup>115</sup> GC 4: "Adolescent Health and Development in the Context of the Convention on the Rights of the Child" (2004) UN.Doc.A/59/41 para.37.

<sup>116</sup> GC 14, (above n.9) para.59.

<sup>117</sup> CESCR, GC 9: "The domestic application of the Covenant" (1998) UN.Doc.E/C.12/1998/24, para.9.

<sup>118</sup> Above, para.14.

<sup>119</sup> *Chorzow Factory* (merits) (1928) PCIJ, Series A no.17, 29.

<sup>120</sup> Art.26, Vienna Convention on the Law of Treaties (VCLT) (1969) UN.Doc.A/CONF.39/27.

<sup>121</sup> GC 9 (above n.117) para.7.

However, even if Uganda does not incorporate these agreements into its national legal order, it remains liable at international level for any violation of the rights it undertook to respect.<sup>122</sup>

Scholars have developed the so-called tripartite typology of state obligations, which makes a distinction between obligations to “respect”, “protect” and “fulfil” each HR.<sup>123</sup> The CESCR has explained each of these obligations with regard to the right to health.<sup>124</sup>

The obligation to respect compels the state to desist from preventing the realisation of a right. Denying or limiting equal access to essential treatment to certain groups, marketing unsafe drugs, or limiting access to healthcare as a punitive measure, would be clear examples of violations.<sup>125</sup>

The obligation to protect requires states to take measures that prevent third parties from interfering with a right.<sup>126</sup> This would include ensuring that privatisation does not constitute a threat to access to essential treatment;<sup>127</sup> to control the marketing and production of medicines by third parties; and to ensure that health professionals meet appropriate standards of education, skills and ethical codes of conduct.<sup>128</sup>

Finally, the obligation to fulfil requires states to adopt appropriate measures towards the full realisation of the right to health.<sup>129</sup> Legislative measures are considered indispensable to combat violations.<sup>130</sup> In addition, appropriate remedies must be available to individuals, and appropriate means of ensuring governmental accountability must be put in place.<sup>131</sup> At policy level, the state is obliged to adopt a national health policy (NHP), based on HR principles, with a detailed plan ensuring provision of healthcare for everyone. In fact, the adoption of such policy constitutes one of the core obligations of the right to health. It should be based on a participatory and transparent process and include indicators and benchmarks, by which progress can be monitored.<sup>132</sup> The strategy should identify the resources available to attain the objectives, and the most cost-effective way of using those resources.

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<sup>122</sup> Art.27, VCLT (above n.120).

<sup>123</sup> Eide (above n.33), Toebe (above n.34) 178.

<sup>124</sup> GC 14 (above n.9) paras.102-110.

<sup>125</sup> As above, para.34.

<sup>126</sup> *Social Economic Rights Action Centre (SERAC) and The Centre for Economic and Social Rights (CESR) v Nigeria* (2001) Communication No.155/96.

<sup>127</sup> Concluding observations-Philippines, UN.Doc.E/C.12/1995/7, para.20.

<sup>128</sup> GC 14 (above n.9), para.35.

<sup>129</sup> As above, para.33.

<sup>130</sup> GC 3 (above n.71) para.3.

<sup>131</sup> GC 9 (above n.117).

<sup>132</sup> GC 14 (above n.9) para.43(f).

## 2.5.2. IMPLICATIONS FOR NON-STATE ACTORS

Traditionally, HR were conceived as applicable to relations between the state and the individuals, to protect the latter from the other more powerful counterpart.<sup>133</sup> However, this distinction has been increasingly challenged, in view of the continuous HR violations committed by non-state actors. Moreover, the wording of the various HR instruments does not support this view, since they include obligations also vis-à-vis third parties.<sup>134</sup> The CESCR has clearly indicated that all members of society have responsibilities regarding the realisation of the right to health,<sup>135</sup> particularly the duty not to restrict access on discriminatory grounds. However, despite these clear HR implications for private actors, it is not yet possible to directly enforce them at international level.<sup>136</sup>

Third party states are bound by articles 55 and 56 of the UN Charter to take joint and separate action to find solutions to international health problems. The ICESCR also imposes on its signatories the furnishing of technical assistance.<sup>137</sup>

Equally, international organisations have the duty to cooperate effectively with states parties, with due respect to their individual mandates.<sup>138</sup> They are, together with states, subjects of international law, and therefore, they are also liable at international level in cases of violations.

## 2.6. CONCLUSIONS

The right of PLWHA to access to essential treatment is recognised in various HR instruments. According to the CESCR, this right forms part of the core content of the right to health, which states must satisfy, whatever their stage of economic development. In addition, access to essential treatment is crucial for the realisation of many other rights recognised in the international instruments of relevance to Uganda.

These international instruments impose on Uganda the obligations to respect, protect and fulfill the right in question, irrespective of the means chosen by the country to implement them at national level. Equally, non-state actors have also undertaken obligations with regard to this right at international level and their interaction in the realisation of this right would need to be assessed.

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<sup>133</sup> N Jägens *Corporate human rights obligations: in search of accountability* (2002).

<sup>134</sup> Preamble, UDHR, ICCPR, ICESCR.

<sup>135</sup> GC 14 (above n.9), para.42.

<sup>136</sup> Jägens (above n.133).

<sup>137</sup> Art.23 ICESCR.

<sup>138</sup> GC 14 (above n.9), para.64.

## CHAPTER THREE

### IMPLEMENTATION OF THE RIGHT TO ACCESS ESSENTIAL TREATMENT IN UGANDA

#### 3.1. INTRODUCTION

The following chapter analyses the status of the right of PLWHA to access to essential treatment in Uganda, with a view to determine to what extent the international obligations emanating from this right have been discharged at national level.

The chapter looks at the three branches of government and their activities towards the respect, protection and fulfilment of the right. It will also analyse the role played by non-state actors in its realisation.

#### 3.2. THE STATE'S RESPONSE TO THE RIGHT TO ACCESS ESSENTIAL TREATMENT IN UGANDA

##### 3.2.1. THE NATIONAL LEGAL FRAMEWORK

##### 3.2.1.1. The Constitution of Uganda

As is normally the case in common law countries, the Ugandan Constitution does not contain a provision automatically incorporating international treaties into the national legal system. Moreover, the right to health and, consequently, the right to access essential treatment, have not been included in Chapter Four of the Constitution, where HR are guaranteed and rendered justiciable.<sup>139</sup> Nonetheless, Objective XIV(b) of the NODPSP sets out the state's duty to ensure that all Ugandans enjoy access to health services, whereas Objective XX expresses the state's commitment to take all practical measures to ensure the provision of basic medical services to the population. Moreover, Objective XXVIII refers to respect for international obligations.

It is certainly regrettable that the right to health as defined in the international instruments binding on Uganda had not been more adequately expressed in the Constitution. Moreover, the inclusion of this right among the NODPSP had the expressed intention to render it "unenforceable and non-binding on

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<sup>139</sup> Art.20(2), 50.

the state".<sup>140</sup> In addition, its location within the introductory provisions of the Constitution, instead of the main body, as it was initially foreseen,<sup>141</sup> also prejudiced its importance.

However, although these objectives are not immediately justiciable, they are meant to serve as guidance in interpreting other provisions of the Constitution or any other law, and implementing policy decisions.<sup>142</sup> In this regard, article 45 of the Constitution sets out that the rights included in Chapter Four should not be regarded as excluding others not specifically mentioned. This inclusive clause, read in conjunction with Objectives XIV, XX, and XXVIII, as well as with the international obligations undertaken by Uganda with regard to the right to health, provides a clear legal basis for rendering this right justiciable under the constitutional enforcement system.

The right to health could also be enforced in Uganda through its link to other rights well entrenched in the Constitution, such as the right to life<sup>143</sup> or freedom from ill treatment.<sup>144</sup>

The non-discrimination aspects of the right to access essential treatment can also be enforced through the equality and freedom from discrimination clause of the Constitution,<sup>145</sup> which is reinforced by various other provisions providing special attention to the rights of women,<sup>146</sup> children,<sup>147</sup> minorities,<sup>148</sup> persons with disabilities,<sup>149</sup> and affirmative action in favour of marginalised groups.<sup>150</sup> Moreover, the right of access to information (and, implicitly, information related to essential treatment) is also guaranteed,<sup>151</sup> as it is the right to education,<sup>152</sup> which should also include HIV/AIDS-related aspects.

Therefore, the regrettable lacuna of the Constitution with regard to the right to health could be overcome by utilising other provisions thereof. Nevertheless, the Ugandan HR Commission (UHRC)'s proposed incorporation of the socio-economic rights in Chapter Four of the Constitution would have been an ideal solution to their disputable justiciability.<sup>153</sup> However, the opportunity was lost during the recent constitutional review, which had no bearing on the status of the socio-economic rights.

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<sup>140</sup> Report of the Uganda Constitutional Commission, cited by Oloka-Onyango (above n.40) 14.

<sup>141</sup> As above.

<sup>142</sup> Objective I(i), NODPSP.

<sup>143</sup> Art.22(1). *The Environmental Action Network (TEAN) v Attorney General (AG) and National Environmental Management Authority (NEMA)*, Misc.Appl. 39/2001.

<sup>144</sup> Art.24. With regard to the interpretation of the Constitution as a whole, see *Tinyefuza v AG*, Constitutional Petition No.1/1997, 14.

<sup>145</sup> Art.21.

<sup>146</sup> Art.33

<sup>147</sup> Art.34.

<sup>148</sup> Art.36.

<sup>149</sup> Art.35.

<sup>150</sup> Art.32.

<sup>151</sup> Art.41.

<sup>152</sup> Art.30.

<sup>153</sup> 2003 Report para.10.09. 1-2.

### 3.2.1.2. Relevant legislation

None of the international HR instruments recognising the right to health have been incorporated into the Ugandan legal system through the adoption of specific legislation. Moreover, access to essential treatment is not specifically dealt with in any national legislation touching upon HIV/AIDS issues. The UAC Act,<sup>154</sup> establishing the organ with the same name, empowers this body with the functions of drafting policy, mobilising resources and coordinating the activities of different stakeholders regarding HIV/AIDS, but does not regulate specific areas of activity. Others, such as the Venereal Diseases Act<sup>155</sup> or the Public Health Act,<sup>156</sup> do not deal specifically with HIV/AIDS and take an approach contrary to HR, providing for quarantine measures, compulsory notification, and compulsory treatment.

Legislation is more prolific with regard to the regulation of drugs. The Food and Drugs Act<sup>157</sup> makes it an offence to sell injurious drugs but does not define what types of drugs would be considered injurious. The Pharmacy and Drugs Act,<sup>158</sup> regulating the profession of pharmacists, only refers in a general manner to professional misconduct in cases of lack of quality of the service. The National Medical Stores (NMS) Act<sup>159</sup> creates the organ with the same name, which, among others, ensures efficient, economic and quality procurement of medicines by the government. Finally, the National Drug Policy and Authority Act<sup>160</sup> creates the National Drug Authority (NDA), in charge of implementing the National Drug Policy (NDP).<sup>161</sup> The law is in the process of being amended to strengthen the role of this body.<sup>162</sup>

The limited scope covered by these legislative measures renders them an inadequate means of guaranteeing the right to health. The right to access to essential treatment is completely disregarded, as it is the HIV/AIDS pandemic itself, and individuals are being deprived of any means to challenge the governmental decisions regarding the provision of essential drugs.

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<sup>154</sup> (1992) Cap.208 *Laws of the Republic of Uganda* (2000), vol.VIII, 4447.

<sup>155</sup> (1977) Cap.284 (as above) vol.XI, 6194.

<sup>156</sup> (1935) Cap.281 (as above) 6084.

<sup>157</sup> (1959) Cap.278 (as above) 6001.

<sup>158</sup> (1971) Cap.280 (as above) 6062.

<sup>159</sup> (1993) Cap.207 (as above) vol.VIII, 4437.

<sup>160</sup> (1993) Cap.206 (as above) 4377.

<sup>161</sup> See below sec.3.2.2.6.

<sup>162</sup> MoH <[http://www.health.go.ug/National\\_drug.htm](http://www.health.go.ug/National_drug.htm)>(accessed 5-9-2005). Other laws regulating the various professions that handle drugs are the Medical and Dental Practitioners Act, Cap.272; the Nurses and Midwives Act, Cap.274; and the Allied Professionals Act, Cap.268.

### 3.2.2. THE NATIONAL POLICY FRAMEWORK

#### 3.2.2.1. The National Health Policy (NHP) and the Health Sector Strategic Plan (HSSP)

Uganda's NHP was adopted in 1999 for a period of ten years.<sup>163</sup> The policy designs a Minimum Health Care Package (MHCP) to provide PHC, which is supposed to be reviewed regularly. Since HIV/AIDS is one of the highest policy priorities,<sup>164</sup> various HIV-related aspects are included within this package, but there is no mention of access to ARVs.

The policy indicates that public expenditure would focus on cost-effective interventions, having the greatest impact on reducing mortality and morbidity, and protecting the most vulnerable population.<sup>165</sup> However, there is no indication on how this will be achieved, and government spending on non-priority healthcare, such as tertiary hospitals, would remain constant.<sup>166</sup>

In addition, the policy undertakes to update and formulate new legislative measures regarding pharmaceuticals, among others, without even referring to the interlinked patent issues.<sup>167</sup>

A general evaluation of the NHP indicates that, to a certain extent, it is driven by HR considerations, but it is not specific in terms of the implementation measures and accountability mechanisms.<sup>168</sup> Most importantly, there is no reference to access to ARVs within the MHCP and the latter is not given absolute priority in terms of health expenditure. The lack of implementation of many of the provisions foreseen, such as the revision of the MHCP or of the laws, confirms its weak legal force.

The HSSP for 2000/1-2004/05 aims at implementing the MHCP. Of the overall costs needed to deliver the MHCP, only US\$ 2 million (1 percent) is allocated to the control of HIV/AIDS. The HSSP attempts to review the NDP, the Pharmacy Act and NDA statute.<sup>169</sup> However, almost five years after the adoption of the HSSP, there is no indication of such review.

The second draft of the HSSP II 2005/06-2009-2010<sup>170</sup> indicates that the health budgetary allocations followed an increasing tendency from 7.6 percent in 2000/01 to 11.5 percent in 2005/06.<sup>171</sup> However, of the total health budget for 2005/06, only 47 percent is government funded, and the slight increase vis-à-vis the previous year corresponds to wages.<sup>172</sup> Unfortunately, the proportion allocated to the

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<sup>163</sup> <<http://www.health.go.ug/docs/NationalHealthPolicy.pdf>>(accessed 3-9-2005).

<sup>164</sup> As above, sec.3.

<sup>165</sup> As above, sec.6.2.

<sup>166</sup> As above, sec.4.3.

<sup>167</sup> As above, sec.13.

<sup>168</sup> Contrary to GC 14 (above n.9) para.43.

<sup>169</sup> As above.

<sup>170</sup> MoH, (2004).

<sup>171</sup> As above, 90.

<sup>172</sup> J Muhwezi, "Health Policy Statement 2005/06" (2005) 71.

provision of essential treatment for PLWHA is not disclosed, although the MoH recognises that it is “largely donor founded”.<sup>173</sup> HSSP II foresees that by 2010, ART will be available in the smallest units (health centre IV).<sup>174</sup>

The HSSP is the only policy paper providing an indication of the budgetary allocations for the strategies planned. The percentage allocated to HIV/AIDS activities for 2000/1-2004/05 is extremely low and, in this regard, it seems that prioritisation of resources bears a lot of weight in the inability of the government to provide full coverage of essential drugs for PLWHA.

### **3.2.2.2. Revised National Strategic Framework for HIV/AIDS activities (NSF)**

The NSF 2003/4-2005/6<sup>175</sup> was adopted after a consultation with different stakeholders. The NSF contains various goals, among which expanding ART to 50% of the population in need<sup>176</sup> and providing 100% OI care. These goals are implemented through the use of policy indicators that enable the MoH to supervise the implementation of ART and TOI across the country.

The NSF can be praised for being precise in its targets and strategies to achieve them, for setting up an evaluation mechanism that allows continuous monitoring, and for being the outcome of public consultation. However, the NSF omits any reference to funding or to the way in which the difficulties of the most vulnerable population to access to essential treatment are going to be tackled. The activities seem to be more focused on training and research than the provision of drugs, and there is no reference to the possibility of utilising the flexibilities provided by trade-related agreements. The absence of a timetable for completion of the targets, or an accountability mechanism, renders this NSF inappropriate to ensure the fulfilment of the right to access to essential treatment.

### **3.2.2.3. The Antiretroviral Treatment Policy (ATP)**

The ATP for Uganda is said to take a HR-approach to HIV/AIDS.<sup>177</sup> The policy proposes a prioritisation of access to ARVs, which favours first cases of MTCT and post-exposure prophylaxis, that is, ART in cases of accidental exposure to the virus or rape victims.<sup>178</sup> In cases of treatment, priority should be given, once clinical eligibility is determined, to HIV-positive mothers identified in MTCT programmes and their infected family members; to HIV-positive children; to PLWHA already enrolled in care activities, and to PLWHA after their participation in ARVs research projects.<sup>179</sup>

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<sup>173</sup> Interview with Dr Lule, AIDS Control Programme at the MoH, (25-09-2005), 9:20-10:00.

<sup>174</sup> HSSP II (above n.170) 44.

<sup>175</sup> UAC & The Uganda HIV/AIDS Partnership, NSF, “A guide for all HIV/AIDS stakeholders” (2004).

<sup>176</sup> Coinciding with the target set up by the “3 by 5” WHO and UNAIDS Global Initiative. As above, 29.

<sup>177</sup> MoH (2003), sec.2.1.

<sup>178</sup> As above, sec.3.11-12, 7.2.

<sup>179</sup> As above, sec.3.11-12.



Outside these cases, people in need of ARVs would have to pay for their treatment.<sup>180</sup> As regards geographic distribution, the policy aims at providing ARVs first in the bigger administrative units (regional hospitals) and progressively in the smaller ones (health centre IV's).<sup>181</sup>

It is unfortunate that the socio-economic situation of those qualifying for treatment has had and still has so little consideration in determining who should have priority access.<sup>182</sup> Moreover, other groups at risk, such as prisoners, rural women or sex workers who are not part of a MTCT programme, are being totally disregarded.<sup>183</sup> Furthermore, the geographic distribution of the drugs should have taken into consideration the proximity of population to a health facility, and the areas with higher HIV/AIDS prevalence, rather than the dimension of the facility itself. Thus, the victims of the conflict in Northern Uganda should have been given preferential access, since the risk of being infected is higher, and the conditions to obtain access to healthcare are more precarious.<sup>184</sup>

Essential drugs for the public sector are procured by the NMS in limited variety and quantity.<sup>185</sup> The policy recognises that the NMS has not been able to ensure a reliable supply of drugs and proposes a service agreement with NMS to outline performance measures for ARVs.<sup>186</sup> Indeed, the persistent stock outs of drugs in hospitals are one of the major concerns with regard to the availability of ARVs.<sup>187</sup> A National Survey indicated that stock-outs duration in public health facilities and district warehouses was three and six months respectively.<sup>188</sup>

The MoH issues accreditations for the provision of ARVs to public facilities only, according to certain requirements.<sup>189</sup> In order to avoid diversion of ARVs from the public sector, the public facilities would need to submit regular reports on the use and status of ARVs and, in addition, drug inspectors would ensure their adequate distribution.<sup>190</sup> The facilities would only maintain stocks for first line ARVs. Drugs for alternate regimens would be stored at the NMS warehouse and be provided on a needed-

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<sup>180</sup> As above, sec.7.3.

<sup>181</sup> As above. According to the MoH, this prioritisation is somehow obsolete now, given that the government has launched universal ART in June 2004, interview at MoH (above n.173). However, one year later the programme is still far from providing access to treatment to all the population in need.

<sup>182</sup> Uganda Coalition for Access to Essential Medicines (UCAEM) "Memorandum on legal mechanisms for expanding access to generic medicines in Uganda" (2003) <<http://www.cptech.org/ip/health/c/uganda/ugandacoalition-memo-11242003.pdf>> (accessed 23-9-2005).

<sup>183</sup> According to the MoH, the itinerant character of prisoners and the lack of interest in being treated with regard to sex workers, impede any programme targeting them to be successful, interview at MoH (above n. 173). These circumstances should not, however, excuse the government to fulfil its obligation to provide access to essential treatment without discrimination.

<sup>184</sup> UCAEM (above n.182).

<sup>185</sup> As above, sec.6.2.2.

<sup>186</sup> As above, sec.6.3.1.

<sup>187</sup> Interview with R Mutambi, Coordinator of UCAEM, C/O Coalition for Health Promotion and Social Development (HEPS) (24-09-2005) 16:00-16:30.

<sup>188</sup> MoH, WHO, HEPS (Health Action International) "Uganda Pharmaceutical sector baseline survey" (2002), 27.

<sup>189</sup> ATP, sec.5.2-3.

<sup>190</sup> ATP, sec.6.3.1.

basis.<sup>191</sup> Surprisingly, private facilities do not seem to be submitted to any control with regard to this issue or procurement of drugs.

The ARVs included in the standard treatment regimes will be considered essential drugs and be included in the EML of Uganda.<sup>192</sup> But the policy does not indicate which drugs, on what criteria they were chosen, and their prices.

Finally, the MoH is meant to monitor the ARV programme both in the public and private sectors, even with regard to the incidence of government subsidies, although it does not indicate how this will be undertaken.<sup>193</sup>

In general, the ATP can be praised for its degree of specification and for having followed, to a great extent, the international guidelines provided by WHO. However, the policy is heavily infused by the model of free market, with lack of control over the private sector and the prices it imposes. In addition, the policy does not establish a long-term timeline estimating the proportion of the population in need that could access drugs for free or at subsidised prices and it does not put in place any accountability mechanism, which is essential, bearing in mind the non-binding nature of the policy.

#### **3.2.2.4. The policy for reduction of MTCT**

The elaboration of a policy for reduction of MTCT in Uganda<sup>194</sup> is justified on the grounds that ART to pregnant women can reduce the risk of MTCT by up to half, and it has proved cost-effective in these circumstances.<sup>195</sup> The policy favours the prescription of Nevirapine, since it is cheaper than any other regime (US\$ 1 per mother-baby pair) and as effective as the others, but alternative regimens are also suggested.<sup>196</sup> The policy recommends extensive information about the risks and benefits of breastfeeding and alternative replacement feeding.<sup>197</sup> The policy indicates that, ideally, an HIV positive mother should not breastfeed but, if the women must do so because of social or economic reasons, then exclusive breast-feeding for three months is recommended.<sup>198</sup>

The policy does not set up a scaling-up programme with targets, and does not take into account the resources, the needs and a timeframe for accomplishment. It merely suggests practices, without

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<sup>191</sup> As above.

<sup>192</sup> As above, sec.6.5.2.

<sup>193</sup> As above, sec.8.1.

<sup>194</sup> MoH (2003).

<sup>195</sup> As above, 5.

<sup>196</sup> As above, 10.

<sup>197</sup> As above, 13.

<sup>198</sup> As above. Surprisingly, though, the policy lists more benefits in breast-feeding than risks.

considering them compulsory, failing to ensure implementation, as required by the Committee of CRC.<sup>199</sup>

### **3.2.2.5. The Uganda National Drug Policy**

The 1993 NDP is embedded in the NDP and Authority Act.<sup>200</sup> A new NDP was adopted in 2001 within the MoH and, although not capable of repealing the previous one, is the one that is being implemented. According to the NDP, the update of pharmaceutical legislation is necessary, as well as the regular review of the EML, at least every three years, using the WHO model list as a basis and taking into account available resources and applicable clinical practices.<sup>201</sup>

Drug quality would be assured through the establishment of a national laboratory and a system of post-marketing surveillance, among others.<sup>202</sup> As regards the prescription of drugs, the NDP will revise at least every three years the standard clinical guidelines, the compulsory prescription of generic names in the public sector and its promotion in the private sector, and encourage reporting on adverse drug reactions.<sup>203</sup>

As regards drug financing, the NDP will ensure adequate budget allocations, it will encourage schemes for the sustainable financing of drugs and the creation of a committee that would investigate available options for funding and disseminate drug indicator prices to suppliers and consumers.<sup>204</sup> The NDP will also ensure that the implications of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) are well understood by the policy-makers.<sup>205</sup> A system of guidelines and indicators for monitoring the NDP is suggested, with evaluation every two-three years.<sup>206</sup>

The NDP is the only policy addressing the TRIPS obligations as well as the sustainable financing of drugs. It is a detailed and ambitious policy in its strategies, but it does not provide a timeline to check compliance. Some of the strategies remain vague, and there is no consideration of HR issues throughout the policy.

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<sup>199</sup> GC 3 (above n.87) para.22.

<sup>200</sup> Above n.160.

<sup>201</sup> As above, 5.

<sup>202</sup> As above 12-13.

<sup>203</sup> As above, 17.

<sup>204</sup> As above, 20.

<sup>205</sup> As above, 21.

<sup>206</sup> As above, 28.

### 3.2.3. JUDICIAL AND OTHER APPROPRIATE REMEDIES RELATING TO ACCESS TO ESSENTIAL TREATMENT

#### 3.2.3.1. Justiciability of the right to access essential treatment in Uganda

The right to access to essential treatment for PLWHA has never been brought before the Ugandan courts. An attempt to bring the right to health was made in *TEAN*,<sup>207</sup> where the applicants, relying upon the ICESCR and the CRC, initially argued that smoking in public places violated this right, as well as the right to life and the right to a healthy environment.<sup>208</sup> Eventually, the applicants pursued their allegations only on the two other rights, probably because of the weak recognition of the right to health in the Constitution.<sup>209</sup> Despite the lost opportunity to test the justiciability of the right to health, this case shows a degree of judicial activism to the extent that, by finding a violation of the right to life and to a safe environment, the High Court implicitly established the link between these rights and the right to health.<sup>210</sup>

In fact, the interpretative value of the NODPDP and the importance of international instruments as a source of inspiration, was already recognised in *Tinyefuza*.<sup>211</sup> The judgement held, moreover, that courts should be dynamic and progressive when interpreting provisions containing fundamental rights, keeping in view socio-economic values.<sup>212</sup> This view led the courts in various jurisdictions to utilise the interdependence of all HR to render the right to health justiciable. In India, for example, the Supreme Court (SC) found that the failure of public hospitals to provide urgent medical treatment to someone because of lack of capacity, violated his right to life.<sup>213</sup> Similarly, in *Cruz Bermudez*,<sup>214</sup> the SC of Venezuela held that the right to health and the right to life of PLWHA that did not have access to ARVs were closely linked to their right to access the benefits from science and technology. Consequently, it ordered the government the provision of free ARVs, TOI and testing for all citizens and residents.

*TEAN* is also relevant in that it recognised the doctrine of public interest litigation in article 50(2) of the Constitution. According to the court, an organisation can bring a public interest action even though it has no direct individual interest in the infringing acts it seeks to have redressed.<sup>215</sup> This finding is

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<sup>207</sup> Above n.143.

<sup>208</sup> *Kiapi* (above n.37) 18.

<sup>209</sup> As above.

<sup>210</sup> See also *Salvatori Abuki & Anor v AG*, Constitutional petition No.2/1997, para.9, where the right to life was found to include right to livelihood.

<sup>211</sup> Above n.144.

<sup>212</sup> As above, 16.

<sup>213</sup> *Paschim Banga Khet Majoor Samity v State of West Bengal* (1996) 4SCC 37; AIR 2426 (SC) para.9.

<sup>214</sup> Above n.70.

<sup>215</sup> *TEAN* (above n.143) 5.

especially relevant with regard to HR litigation since, as indicated by Tibatemwa, through public interest litigation the disadvantaged sections of society can meaningfully access justice.<sup>216</sup>

In *Osotraco (U) Ltd. v AG*,<sup>217</sup> the Ugandan High Court found that article 50(1) of the Constitution assures a person *effective* redress before the courts for violations of their rights. The court found that “a less than appropriate redress is not effective redress”.<sup>218</sup>

The appropriateness of the redress, when adjudicating on access to essential treatment, may be problematic because of its link with the availability of resources of the government. In the SA jurisprudence, resource constraints were one of the factors in the review of the “reasonableness” of the programme adopted by the administration to provide access to treatment.<sup>219</sup> According to the SA Constitutional Court (CC), considering “reasonableness” will not enquire whether other more desirable measures could have been adopted. However, it will take into consideration whether the measure grants at least minimum core entitlements to those most in need of them.<sup>220</sup>

The Colombian courts went even further, arguing that the public purpose of containing an epidemic such as HIV/AIDS cannot be made subservient to resource constraints.<sup>221</sup> Consequently, it granted an order made by an AIDS patient to compel a hospital to arrange for the immediate provision of services.

Canadian courts have, on the other hand, held that resource constraints cannot serve to justify a violation but can be taken into consideration when tailoring the appropriate remedy.<sup>222</sup> On the same line, in *Treatment Action Campaign (TAC)*<sup>223</sup> the SA CC ordered the roll-out of a MTCT programme throughout the public sector because of its limited resource implications, among others.<sup>224</sup> This judgement was also relevant because it pointed to the cost-benefits of the provision of essential treatment.<sup>225</sup>

Other argument that could be raised against the justiciability of access to essential treatment is the fact that the judiciary would break into spheres better dealt with by the legislature and the executive. This is either because the judiciary has not the expertise to deal with budgetary implications, or

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<sup>216</sup> Tibatemwa-Ekirikubinza, (above n.46).

<sup>217</sup> HCCS 1380/1986 (unreported).

<sup>218</sup> As above, paras.46, 48.

<sup>219</sup> *Soobramoney v Minister of Health (KwaZulu-Natal)* (1997) (12) BCLR 1696.

<sup>220</sup> *Government of the Republic of SA and others v Grootboom and others*, (2000) (11) BCLR 1169 (CC); para.41.

<sup>221</sup> Tutela No. T-505/92 (1992).

<sup>222</sup> *Schachter v Canada* (1992) 10 CRR 1.

<sup>223</sup> *Minister of Health and others v Treatment Action Campaign and others* (no.2) 2002(5) SA 721(CC).

<sup>224</sup> Above, para.135.

<sup>225</sup> Above, para.116.

because this would threaten the separation of powers.<sup>226</sup> The SA CC held in *TAC* that the *limited* judicial review may have budgetary implications, but courts are not directed at rearranging budgets.<sup>227</sup> SA courts took, however, a new approach in the most recent jurisprudence, which advocates for a participatory model of democracy that overcomes the strict separation of powers and provides equal political power to the citizenry.<sup>228</sup> Another solution purported by the Indian courts to overcome lack of expertise is to rely on the findings of an expert body to provide the remedy.<sup>229</sup>

Despite the positive steps taken by the Ugandan courts, the enforcement of HR has been somehow prejudiced by the confusion existent on whether the CC is competent in terms of article 50 of the Constitution to enforce HR, or whether its jurisdiction is limited to interpretation issues, according to article 137.<sup>230</sup> Since *Rwanyarare & Afunadula v AG*,<sup>231</sup> the CC held that it had no jurisdiction in matters not covered by article 137. In *George William Alenyo v AG & 2Ors*,<sup>232</sup> however, the CC clarified that it could also deal with petitions brought under article 50 as long as they were brought within the context of interpretation of article 137.<sup>233</sup> Consequently, its primary role would be to make a declaration on the meaning, but could also grant redress if appropriate.<sup>234</sup> In *Joyce Nakacwa v AG & 2Ors*, the CC further clarified that any court would be obligated to submit to it interpretation issues, even if the matter involves also enforcement aspects.<sup>235</sup>

Despite these clarifications, there seems to be a fine line between interpretation and application of the Constitution that could frustrate the viability of many petitions. Moreover, the possibility of obtaining a mere declaration from the CC does not provide sufficient reparation for the victims. Indeed, the lack of actions brought before the courts regarding access to essential treatment denotes a lack of confidence in the judicial system with regard to the enforcement of socio-economic rights.

### **3.2.3.2. Other remedies available with regard to the right to access essential treatment**

The UHRC offers another useful means of enforcing fundamental rights in Uganda. This organ is mandated by the Constitution with the quasi-judicial function of investigating, by its own initiative or on a complaint, HR violations.<sup>236</sup> In addition, this body is mandated to recommend the Parliament

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<sup>226</sup> Viljoen, (above n.42) 33.

<sup>227</sup> Para.18.

<sup>228</sup> Eg *Port Elisabeth Municipality v various occupiers* (2004) (12) BCLR 12 68 (CC).

<sup>229</sup> Above n.213.

<sup>230</sup> Onoria (above n.47) 360.

<sup>231</sup> Constitutional Petition No.11/1997.

<sup>232</sup> Constitutional Petition No.5/2000.

<sup>233</sup> As above, para.7.

<sup>234</sup> As above, 8.

<sup>235</sup> Constitutional petition No.2/2001, 15.

<sup>236</sup> Art.52(1)(a), Constitution.

effective measures to promote HR, including compensations to the victims.<sup>237</sup> Another important function is to monitor government's compliance with HR treaties.<sup>238</sup>

In its recommendations to Parliament throughout the years, the UHRC suggested the adoption of a national health insurance policy for the subsidisation of ARVs,<sup>239</sup> and the coordination of efforts at African level to raise awareness on the implications of intellectual property rights (IPR).<sup>240</sup> Unfortunately, the legislative branch has not followed up the majority of these recommendations.

In the latest annual report published, the UHRC reports a case of alleged medical experimentation without consent and indicates that, although there are many more cases related to HIV/AIDS, they are not reported for lack of awareness.<sup>241</sup> The UHRC recommended measures to ensure that the private pharmaceutical companies subsidise the drugs.<sup>242</sup> It also suggested mechanisms to monitor the administration of drugs, including by private dealers.<sup>243</sup> According to the UHRC, more focus should be put on the poor and the population in conflict areas, and on the revision of laws.<sup>244</sup>

The UHRC has also been very progressive in the recognition of socio-economic rights, as demonstrated in the case of *Kalyango Mutesasira & Anor v Kunsu Kiwanuka & Ors*.<sup>245</sup> The UHRC read in article 254 of the Constitution a right to a pension,<sup>246</sup> and it referred to the binding obligations under article 9 ICESCR in support of its arguments.<sup>247</sup> Moreover, it further argued that it was wrong to leave social security payments at the mercy of government,<sup>248</sup> thereby rejecting to subject the realisation of the right to the availability of resources.<sup>249</sup> In addition, the UHRC can be praised for having granted adequate compensations to victims of violations, which unfortunately are not always honoured by the government.

In view of the prolific activity of the UHRC, the government's proposal to eliminate this organ can only be considered a retrogressive step in the protection of HR in Uganda.<sup>250</sup> According to the institution, the main beneficiaries of the complaint-handling process are marginalised groups, because they

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<sup>237</sup> Art.52(1)(d), Constitution.

<sup>238</sup> Art.52(1)(h), Constitution.

<sup>239</sup> 2000-2001 annual report, 74.

<sup>240</sup> 1998 annual report, 42-43.

<sup>241</sup> 2003 annual report, para.15.08.

<sup>242</sup> As above, para.15.52.

<sup>243</sup> As above.

<sup>244</sup> As above.

<sup>245</sup> UHRC complaint No.501/2001.

<sup>246</sup> As above, 8-9.

<sup>247</sup> As above, 4-5.

<sup>248</sup> As above, 6.

<sup>249</sup> Onoria (above n.47) 359.

<sup>250</sup> Proposal of the Government of Uganda for amendment of the 1995 Constitution presented to the Constitutional Review Commission (2003).

cannot afford access to justice in the regular courts.<sup>251</sup> Thus, its elimination would close another channel towards the realisation of this right for the most vulnerable groups.

### **3.3. THE RESPONSE OF NON-STATE ACTORS TO THE RIGHT TO ACCESS ESSENTIAL TREATMENT IN UGANDA**

In addition to the public sector, treatment is also provided through NGOs, community-based centres, or faith-based organisations.<sup>252</sup> All these centres are donor-funded and share to a great extent the burden of the government to provide ARVs. As indicated by Oloka-Onyango, the intervention of these organisations has been more from a welfarist, rather than an activist point of view.<sup>253</sup> The majority has never considered the possibility of bringing an action for the enforcement of the right to essential treatment, despite the great opportunity that public interest litigation represents, or the flexibility of the complaint mechanism before the UHRC.<sup>254</sup> The fact that many NGOs are receiving funds from GF or PEPFAR initiative can also bias their advocacy work and level of criticism with regard to the provision of ARVs.<sup>255</sup>

Noteworthy is also the initiative undertaken by various companies in the private sector to afford ART to HIV-positive workers and, in some occasions, their families.<sup>256</sup>

As regards the international organisms, the most important actor is WHO, which has taken the HIV/AIDS care agenda from UNAIDS to provide support in the development of policies and drug procurement, among others.<sup>257</sup>

Uganda benefits largely from the international donor community, to the extent that 53 percent of its national budget for 2005/06 comes from grants and loans.<sup>258</sup> According to WHO, between US\$ 69.2 million and US\$ 131.7 million were required to reach the “3 by 5” target for Uganda of 55 000 people by the end of 2005.<sup>259</sup> This budget was reached with PEPFAR’s contribution alone, which provided

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<sup>251</sup> A Makubuya, “National human rights institutions under the fire: the Uganda Human Rights Commission on the brink” (2004) 10(1) *EAJPHR* 86.

<sup>252</sup> WHO (above n.4) 1.

<sup>253</sup> Oloka-Onyango (above n.40) 48.

<sup>254</sup> Interview with P Ssebanjja, Advocacy and capacity building director of The AIDS Support Organisation (TASO), (20-09-2005) 11:50-12:19; interview with M Ruhindayo, Project Manager at the Health Rights Action Group (HAG) (23-09-2005) 12:00-12:18; interview with H Darson, Assistant Information Officer at Uganda Network of AIDS Service organisations (UNASO) (20-09-2005) 14:30-15:00.

<sup>255</sup> Interview at HEPS (above n.187).

<sup>256</sup> S Tamale “Gender, Work & HIV/AIDS: Reflections of the case of Uganda” (2004), paper submitted to the UN Economic Commission for Africa, 45.

<sup>257</sup> The role of UNAIDS was particularly relevant for the development of the Drug Access Initiative, which showed the feasibility of providing ARVs in a resource-limited setting. J Serutoke (WHO) “Accelerating access to comprehensive HIV/AIDS care with emphasis on antiretroviral therapy in Uganda”, <[www.who.int/medicines/organization/par/EssMed\\_25thAnniversary/2-access/accel\\_access\\_uganda.ppt](http://www.who.int/medicines/organization/par/EssMed_25thAnniversary/2-access/accel_access_uganda.ppt)>(accessed 12-9-2005).

<sup>258</sup> II HSSP (above n.170).

<sup>259</sup> WHO (above n.4) 3.



close to US\$ 142 million during 2004-2005.<sup>260</sup> In addition to this, Uganda benefited from the World Bank (WB) Multi-Country HIV/AIDS Program for Africa, from US\$ 2 million received from multilateral sources and from US\$ 1 million received from NGOs.<sup>261</sup> To top it all, the total funding estimated to be available for treatment from GF is about US\$ 35.1 million for 2004-2005.<sup>262</sup> The government itself was expected to commit estimated US\$ 5.6 million to scaling up ART during 2004-2005,<sup>263</sup> although the only amounts budgeted for HIV/AIDS control issues that were publicly available were US\$ 2 million for five years.<sup>264</sup>

Bearing in mind these funds (US\$ 185.7, US\$54 in excess of the maximum amount required by WHO), it is not surprising that Uganda reached its target six months ahead schedule.<sup>265</sup> In fact, what is surprising is that the number of people acceding ARVs in Uganda is only 63,896,<sup>266</sup> or that only 10,600 people of those are acceding ARVs free-of-cost.<sup>267</sup> In a country where 35 percent of the population lives with less than a dollar per day,<sup>268</sup> the cost of a first-line regimen remains unaffordable, even if it represents only US\$ 180 per person per year.<sup>269</sup> The public health goal cannot simply be the reduction of morbidity and mortality for those targeted, but for the whole population in need,<sup>270</sup> to the extent that the resources available allow.

These diverse funds call into question the effective coordination between the different donors.<sup>271</sup> Moreover, the amount of funds directed to preventive measures clearly outweighs that channelled towards essential treatment.<sup>272</sup> The recent decision of GF to temporarily suspend all the grants to Uganda because of evidence of serious mismanagement<sup>273</sup> challenges also the reliability of the structures set up to administer those funds and the effective “unavailability of resources” of this country to meet up its core obligations.

### 3.4 CONCLUSION

An analysis of the measures adopted at national level indicates that Uganda has not made every effort to satisfy, as a matter of priority, this minimum content of the right to health. Indeed, the legislative

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<sup>260</sup> As above.

<sup>261</sup> As above.

<sup>262</sup> As above.

<sup>263</sup> As above.

<sup>264</sup> HSSP 2000/01-2004/05, above sec.3.2.3.1.

<sup>265</sup> WHO (above n.4), 1.

<sup>266</sup> Instead of 74 000, as it would correspond following WHO maximum budgetary estimations.

<sup>267</sup> WHO (above n.4), 3.

<sup>268</sup> Millennium report, <[www.unmillenniumproject.org/ documents/TF5-medicines-Appendixes.pdf](http://www.unmillenniumproject.org/documents/TF5-medicines-Appendixes.pdf)>(accessed 10-9-2005).

123.

<sup>269</sup> WHO, (above n.4), 1.

<sup>270</sup> M Desvarieux *et al*, “Anti-retroviral therapy in resource-poor countries: illusions and realities” 95(7) *American Journal of Public Health* (2005) 1117.

<sup>271</sup> According to the DIIS (above n.20) 12, PEPFAR is perceived as duplicating many of GF’s activities.

<sup>272</sup> The amount of funds allocated to ARVs by GF represented 30 percent of the total funds granted, WHO, (above n.4).

<sup>273</sup> GF (above n.13). See also sec.4.3 below.

framework in place is outdated and completely inadequate to tackle the epidemic. The measures at policy level do not provide a structured response to the problem, and they do not identify the resources available and needed for achieving the objectives. Furthermore, the resources mobilised at national level are insufficient and those obtained from the donor community do not seem to be handled in the most effective way.

The justiciability of the right to access to essential treatment faces also some obstacles, derived from its weak recognition in the Constitution, the conservative approach taken by some of the courts, and the lack of activism among the civil society. Moreover, its justiciability through the UHRC seems to be threatened by the risk of eliminating this body or weakening its powers.

## CHAPTER FOUR

### OBSTACLES TO THE REALISATION OF THE RIGHT TO ACCESS ESSENTIAL TREATMENT IN UGANDA

#### 4.1 INTRODUCTION

This chapter analyses the situation on the ground in Uganda and identifies some of the obstacles that impede access to essential treatment. An analysis of these factors is necessary in order to better understand the reasons behind the insufficient response given by the government of Uganda to access to essential treatment. Moreover, by acknowledging the interaction of different factors and role-players, this analysis will help to provide more comprehensive and tailored recommendations.

#### 4.2 IMPACT OF THE GLOBALISATION PROCESS ON ACCESS TO ESSENTIAL TREATMENT

##### 4.2.1 CONCEPTUALISATION OF THE GLOBALISATION PROCESS

According to the International Monetary Fund (IMF), globalisation refers to the increasing integration of economies around the world, particularly through trade and financial flows.<sup>274</sup> Many other definitions have been given with regard to this process,<sup>275</sup> but for the purpose of this study, globalisation means the process whereby states are compelled by the international economic forces to take measures that negatively impact on the enjoyment of the right of PLWHA to access essential treatment. This section will focus on how the decisions of the multilateral institutions impact on the measures of the government to tackle the major barriers to access to essential treatment, which are insufficient budgetary allocations, poverty and insufficient health infrastructure. It will also look at how the international trade regime established by the World Trade Organisation (WTO) influence on access to essential treatment.

##### 4.2.2 THE ROLE OF THE POLICIES OF INTERNATIONAL FINANCIAL INSTITUTIONS (IFIs) ON BARRIERS TO ACCESS ESSENTIAL TREATMENT

###### 4.2.2.1 Insufficient health budgetary allocations and the role of IFIs

As indicated above, the 2005/06 increase in the health budgetary allocations was due to a raise on the amount allocated to wages, and had no impact on the health infrastructure or provision of drugs.<sup>276</sup>

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<sup>274</sup> IMF, "Globalisation threat or opportunity?" <<http://www.imf.org/external/np/exr/ib/2000/041200.htm#11>>(accessed 10-10-2005).

<sup>275</sup> Twinomugisha (above n.36) 76.

<sup>276</sup> Health Policy statement (above n.172). As indicated above, ARVs are largely donor-founded.

Consequently, civil society has urged the government to meet its commitment at the Abuja Summit<sup>277</sup> to allocate at least 15 percent to health matters.<sup>278</sup>

However, an important factor that prevents the government to increase public health spending is the policy of the IMF to keep budget ceilings in order to maintain macroeconomic stability.<sup>279</sup> This explains the Ministry of Finance (MoF)'s initial rejection to the 2003 GF's grant, indicating that Uganda would have to cut out that amount from the existing health budget because an excessive inflow of foreign aid could lead to currency overvaluation.<sup>280</sup> Due to public pressure, however, the MoF eventually agreed.<sup>281</sup> Nonetheless, despite IMF's statement that the acceptance of GF's grant and its use to top priority spending would not have an adverse effect on the macro economy,<sup>282</sup> the organisation still argues that raising national levels of inflation would serve only "to create uncertainty and complicate macroeconomic management".<sup>283</sup> These comments overlook the fact that, even from a mere economic point of view, the provision of ARVs allows the government to save money by reducing hospitalisation costs and increasing the productivity of PLWHA and their relatives at work.<sup>284</sup>

Since 1998, Uganda has benefited from the WB Heavily Indebted Poor Countries Initiative, aiming at ensuring debt relief with a link to poverty reduction.<sup>285</sup> However, this initiative has not succeeded to reduce Uganda's debt load to sustainable standards,<sup>286</sup> and this leads to further borrowings under IMF's strict conditions.

Finally, IMF's open preference for HIV-preventive measures against treatment measures could also have influenced the spending decisions of the government.<sup>287</sup> The organisation seems to disregard the fact that access to essential treatment is a right, not an economic choice for governments, which cannot be taken away simply because of its financial implications. Prevention and treatment should be complementary aspects of the action to fight HIV/AIDS.

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<sup>277</sup> Abuja Declaration on HIV/AIDS, tuberculosis and other related infectious diseases (2001) OAU/SPS/ABUJA/3 26.

<sup>278</sup> Uganda AIDS Advocacy Network "Dr Nelson Musoba's Presentation of a Letter to Hon Dr Elioda Tumwesigye" <[www.phrusa.org/campaigns/aids/uganda/musoba.php](http://www.phrusa.org/campaigns/aids/uganda/musoba.php)>(accessed 12-9-2005).

<sup>279</sup> R Rowden (Action Aid *et al*) "Blocking progress: How the fight against HIV/AIDS is being undermined by the World Bank and International Monetary Fund" (2004) <<http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/CSO/0,,contentMDK:20127029~menuPK:277368~pagePK:220503~piPK:220476~theSitePK:228717,00.html>>(accessed 25-9-2005), 1.

<sup>280</sup> As above. This reason was rejected by J Sachs

<[http://www.eurodad.org/uploadstore/cms/docs/crs\\_sachs\\_uganda.doc](http://www.eurodad.org/uploadstore/cms/docs/crs_sachs_uganda.doc)>(accessed 20-9-2005).

<sup>281</sup> As above.

<sup>282</sup> T Dawson "A Response to ActionAid International and Other Organizations" (2004)

<[www.imf.org/external/np/vc/2004/093004.htm](http://www.imf.org/external/np/vc/2004/093004.htm)>(accessed 27-9-2005).

<sup>283</sup> As above.

<sup>284</sup> Desvarieux (above n.270), 1117.

<sup>285</sup> WB, Uganda-country brief (2005)

<<http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/UGANDAEXTN/0,,menuPK:374947~pagePK:141132~piPK:141107~theSitePK:374864,00.html>>(accessed 22-9-2005).

<sup>286</sup> Jubilee USA Network "Uganda-factsheet" <[http://www.jubileeusa.org/learn\\_more/uganda.pdf](http://www.jubileeusa.org/learn_more/uganda.pdf)>(accessed 30-9-2005).

<sup>287</sup> M Haacker, "The impact of HIV/AIDS on government finance and public services" in *The Macroeconomics of HIV/AIDS* (2004) 216, <<http://www.imf.org/external/pubs/ft/AIDS/eng/index.htm>>(accessed 3-9-2005).

#### 4.2.2.2 Poverty and the role of the IFIs

The entire key informants interviewed during this research mentioned poverty as the major barrier to access to essential treatment.<sup>288</sup>

In 1999, the IFIs adopted the Poverty Reduction Strategy Papers (PRSP), which are the basis on which lending and public debt relief is granted in developing countries.<sup>289</sup> Uganda's PRSP is based on a revision of its Poverty Eradication Plan (PEAP), which was adopted for the first time in 1997.

The expenditure implications of the PEAP are translated by the MoF into concrete spending decisions through a macroeconomic model designed by the IMF that determines rigid budget ceilings for each ministry.<sup>290</sup> Thus the margin left in the budgeting process for social and HR considerations, as well as for national public involvement is minimal, since they can neither question the model nor the ceilings. Moreover, the lack of efficiency of these macroeconomic strategies is demonstrated by the fact that the percentage of the population living below the poverty line in Uganda has increased from 34% in 2000 to 38% in 2003, and HIV/AIDS morbidity is one of the major reasons for this raise.<sup>291</sup>

#### 4.2.2.3 Insufficient public healthcare infrastructure and personnel and the role of IFIs

Insufficient healthcare infrastructure and personnel was also one of the most cited barriers to access to essential treatment by key informants. Hence, it is surprising that only 20 percent of the health budget for 2004/05 was allocated to public healthcare units in the country, whereas 53 percent was allocated to the MoH and the UAC alone.<sup>292</sup> Moreover, allocations to district health services dramatically decreased during this period (from 54 percent to 29 percent) whereas allocations to the MoH headquarters increased considerably (from 24 percent to 46 percent).

The state has encouraged an increasing role of private actors in the health service delivery, following the recommendations of the IFIs.<sup>293</sup> The idea behind privatisation is that government can save money and shift liability to the private sector.<sup>294</sup> However, these macroeconomic arguments disregard the fact that the government is still liable to ensure that privatisation does not constitute a threat to access to

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<sup>288</sup> E.g., interview with R Musoke, Legal adviser in charge of HIV/AIDS at the Law Reform Commission (LRC) (30-09-05), 13:45-14:10; interview with Dr M Nannyonga, Head of Homecare department at St Francis' Hospital Nsambya, (26-09-05), 12:30-13:00; Interview with Dr Namulema, Head of AIDS department at Mengo Hospital, (11-10-05), 15:00-15:30.

<sup>289</sup> IMF, PRSP factsheet, <<http://www.imf.org/external/np/exr/facts/prsp.htm>>(accessed 30-9-2005).

<sup>290</sup> Uganda Debt Network (UDN) "Uganda's Poverty Reduction Strategy Papers and resource allocation to the health sector" (2003), 22.

<sup>291</sup> MoF, PEAP (2004), xv.

<sup>292</sup> Report of the Parliament's Commission of Social Services <[http://www.parliament.go.ug/social%20rpt7\\_session4.htm](http://www.parliament.go.ug/social%20rpt7_session4.htm)> (accessed 20-9-2005).

<sup>293</sup> Twinomugisha (above n.36) 80.

<sup>294</sup> As above.

essential treatment.<sup>295</sup> Although in many cases essential treatment is provided free-of-charge through not-for-profit organisations, the government should not be released of its obligation to provide for sustainable solutions, should these organisations stop their activities in the future.

### 4.2.3 THE ROLE OF THE INTERNATIONAL TRADE REGIME

#### 4.2.3.1 Impact of the international trade regime on access to essential treatment

By becoming a member of WTO right after the entry into force of the agreement creating this organisation in 1995,<sup>296</sup> Uganda was automatically bound by those agreements made in the Uruguay Round document. These include the TRIPS,<sup>297</sup> the most relevant trade agreement for access to essential treatment.

According to this agreement, member countries must provide, among others, patent protection for a minimum of twenty years on new drugs.<sup>298</sup> This enables patent-holders to set up prices for their new drugs higher than those that would be obtained in a competitive market, as a return for the investment incurred.<sup>299</sup> Therefore, since most HIV-related drugs are under patent protection, this agreement restricts access to essential treatment by raising its cost implications.

TRIPS indicates, however, that states have the right to protect public health as long as this is done within the provisions of the agreement.<sup>300</sup> To that effect, TRIPS provides a series of flexibilities, among which, the exception foreseen in article 30, mainly for research purposes or to obtain marketing approval just before the patent expires (the “regulatory exception”). TRIPS also allows parallel importation, that is, the importation, without the patent-owner’s approval, of products marketed by the patent-owner at cheaper prices in another country.<sup>301</sup> But perhaps the most important flexibility is the possibility for a government, or for a company authorised by the government, to produce drugs under compulsory licence, that is, without the patent-owners’ approval, provided prior request for a voluntary licence was not successful<sup>302</sup> and compensation was paid to the patent-owner.<sup>303</sup> However, the licence had to be granted predominantly to supply the domestic market, and this rendered this possibility of no use for those countries, like Uganda, that lacked the capability to produce drugs.

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<sup>295</sup> GC 14 (above n.9) para.35.

<sup>296</sup> WTO <[http://www.wto.org/english/thewto\\_e/whatis\\_e/tif\\_e/org6\\_e.htm](http://www.wto.org/english/thewto_e/whatis_e/tif_e/org6_e.htm)>(accessed 29-10-2005).

<sup>297</sup> TRIPS (1994).

<sup>298</sup> Art.27(1), 33 TRIPS.

<sup>299</sup> C Correa, “Implications of the Doha Declaration on the TRIPS Agreement and Public Health” (2002).

<sup>300</sup> Art.8 TRIPS.

<sup>301</sup> Art.6 TRIPS.

<sup>302</sup> Except in cases of national emergencies or government use.

<sup>303</sup> Art.31 TRIPS.

In Doha, the difficulties of LDCs to enforce patent protection purported an extension of the period granted to them to comply with TRIPS from 2006 to 2016.<sup>304</sup> However, this did not resolve the problem of LDCs that lacked the capability to produce drugs, and could not import them either from those countries where TRIPS rules were in force. The major source of supply for LDCs was, therefore, those developing countries, such as India, which did not provide patent protection for pharmaceuticals and had developed a generic pharmaceutical industry that was able to provide drugs at significant lower prices. However, this source of supply was coming to an end, since these developing countries had until January 2005 to provide patent protection for pharmaceutical products.

As a result, a 2003 General Council decision waived exporting countries' obligation to produce "predominantly" for their markets, allowing them to issue compulsory licences for the exclusive supply of a country, mainly LDCs, provided certain conditions were met to prevent diversion of medicines.<sup>305</sup> The Decision waived also the obligation to pay compensation to the patent owner in the importing country.<sup>306</sup>

Although these were positive steps, they did not focus on improving the capacity of LDCs to create an industry of their own. Indeed, developed countries have made little effort to promote the transfer of technology to LDCs, as required in article 66(2) TRIPS.<sup>307</sup> Moreover, some developed countries are using their positions as trading partners and donors to push LDCs for the adoption of agreements that guarantee further protection to patent-holders (TRIPS-Plus agreements),<sup>308</sup> to restrict the suppliers of ARVs through their aid programmes to patent-holding companies, or to impose quick implementation of patent laws.

#### **4.2.3.2 Implementation of the international trade regime in Uganda**

Uganda has in place a Patents Statute since 1991. Although the country had several years to bring its legislation in conformity with TRIPS,<sup>309</sup> it rushed into a revision process as early as in 1998, following the argument from USAID that the country was losing out on foreign investment and technology transfer.<sup>310</sup> This revision raised considerable criticism from civil society, who claimed that there should have been a broader public consultation<sup>311</sup> and that the involvement of US consultants and USAID

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<sup>304</sup> Para.7 of the Doha Declaration on TRIPS and Public Health (2001) WTO Doc WT/MIN(01)/DEC/2.

<sup>305</sup> WTO, Decision on the implementation of paragraph 6 of the Doha Declaration on the TRIPS agreement and public health, (2003) WTO Doc WT/L/540.

<sup>306</sup> As above, para.3.

<sup>307</sup> Para.7, Doha Declaration.

<sup>308</sup> Correa (above n.49) 7.

<sup>309</sup> First until 2006 and then, after the Doha Declaration, until 2016.

<sup>310</sup> A Mpeirwe "Uganda: Lessons for reform" in The Panos Institute, *Patents, pills and public health, Can TRIPS deliver?* (2002) 48, <[http://www.panos.org.uk/PDF/reports/TRIPS\\_low\\_res.pdf](http://www.panos.org.uk/PDF/reports/TRIPS_low_res.pdf)>(accessed 20-9-2005).

<sup>311</sup> HAI News "Civil Society Organizations concern as Uganda rushes to implement TRIPS, 5 years ahead of deadline", July-September 2001 <<http://www.haiweb.org/pubs/hainews/200107.html>>(accessed 4-9-2005).

would result in a legislation that suits US' purposes.<sup>312</sup> This reaction seemed to have positively influenced the direction of the discussions towards a text that suspends the application of patent legislation for pharmaceuticals until 2016, and includes other flexibilities, such as compulsory licensing and parallel importation.<sup>313</sup>

The current Patents Statute grants a high protection to patent-holders, since it totally excludes parallel importation,<sup>314</sup> the regulatory exception,<sup>315</sup> and restricts the application for compulsory licenses to very limited grounds.<sup>316</sup> However, it also contains some flexibilities, such as the possibility for the MoH to request patent-holders to surrender their patents rights in Uganda, for example until 2016.<sup>317</sup> Certain products could also be excluded from patentability "in the public interest" for a period of two years. The Minister of Justice can also order the exploitation of a patent invention "for matters of paramount importance" pertaining, among others, to public health, provided that the patent-owner has been given an opportunity to be heard and adequate remuneration is paid.<sup>318</sup>

In reality, none of these flexibilities have been utilised by the government so far. According to HEPS, the reasons are the fear of lawsuits from big pharmaceutical companies and of retaliation measures from the US.<sup>319</sup> Indeed, these threats are not negligible, since the risk of losing the US, as a partner in trade<sup>320</sup> and one of the major donors, is too high to be overlooked.

US' protection of pharmaceutical companies can also be felt in the way it handles the PEPFAR initiative in Uganda, since all the ARVs bought under this programme are branded.<sup>321</sup> This requirement not only impedes the use of funds to buy cheaper drugs and treat more people and for a longer period of time, but also affects adherence and supply, since generic ARVs can be provided in a much easier way through fixed-dose combinations in one tablet.<sup>322</sup>

It is worth noting that, although various generic versions of ARVs are now registered with the NDA, they are legally subject to challenge.<sup>323</sup> It seems that their use in Uganda is being "tolerated" by the

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<sup>312</sup> GM Watch "US turning AIDS into big business/USAID=big business" (20-07-2004) <<http://www.gmwatch.org/p1temp.asp?pid=37&page=1> >(accessed 12-9-2005).

<sup>313</sup> Interview at LRC (above n.288).

<sup>314</sup> Sec.25.

<sup>315</sup> Sec.26.

<sup>316</sup> Sec.31.

<sup>317</sup> Sec.36.

<sup>318</sup> Sec.30.

<sup>319</sup> Testimony registered by DIIS (above n.20) 44.

<sup>320</sup> Uganda is one of the major beneficiaries of the Africa Growth and Opportunity Act (AGOA), a US initiative giving free access to a number of products from African countries.

<sup>321</sup> DISS (above n.20) 30.

<sup>322</sup> As above.

<sup>323</sup> A Martinez-Jones *et al* (Oxfam) "Access to antiretroviral therapy in Uganda" (2002).



global pharmaceutical companies, as part of an informal agreement with the government, “as long as the number remains small”.<sup>324</sup>

Local inventions have been rare in Uganda, due to the absence of research and development capacity,<sup>325</sup> and the small size of the economy.<sup>326</sup> In any event, competition with large pharmaceutical companies would be very difficult, since the latter can profit from economies of scale and sell at low prices.<sup>327</sup> Moreover, any attempt of subsidising the prices of local drugs could give rise to litigation within the WTO because of discriminatory practices.<sup>328</sup>

### 4.3 LACK OF ACCOUNTABILITY MECHANISMS AND GOOD GOVERNANCE

As indicated in chapter three, the lack of accountability mechanisms in all the policies related to the provision of essential treatment for PLWHA in Uganda is outstanding.

Transparency mechanisms are also missing with regard to the management of funds. The auditor’s report providing *prima facie* evidence of “serious mismanagement” of the funds received by the MoH from GF<sup>329</sup> clearly shows that mismanagement happens and may still happen in the future if no mechanisms are put in place to stop these practices. The reaction of the government to appoint a commission of inquiry on the matter,<sup>330</sup> instead of allowing the criminal justice system to take care of it does not, in my opinion, demonstrate a sufficient political commitment towards the eradication of these practices. Indeed, the discretion given to the President to appoint the members of such commission and to disregard its findings if he wishes may take away the possibility of justice being done, although it is unlikely that this will happen, in view of the international impact this could have.<sup>331</sup> While in the case at hand a motion of censure against the Minister of Health did not succeed in Parliament,<sup>332</sup> it should be noted that such mechanism has not proved efficient in the past to fight corruption.<sup>333</sup>

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<sup>324</sup> Testimony of a pharmacy manager, DIIS (above n.20) 43.

<sup>325</sup> As above.

<sup>326</sup> S Musungu, *et al* “Utilising TRIPS flexibilities for public health protection through South-South regional frameworks” (2004) 1627.

<sup>327</sup> Although Uganda could bring an anti-dumping complaint in case of unfair practices, it is unlikely that it would be willing to involve itself in a protracted litigation process.

<sup>328</sup> Wandira (above n.18).

<sup>329</sup> GF (above n.13).

<sup>330</sup> F Nyakairu (Daily Monitor) “GF inquiry starts” (14-9-2005) 4.

<sup>331</sup> It should be noted, though, that the findings of previous commissions were not followed up. C Mwanguhya (Daily Monitor) “Ministers won’t resign over GF cash” (2-9-2005), 1-2.

<sup>332</sup> K Ssemogere (Daily Monitor), “The post-mortem of Muhwezi’s censure” (22-9-2005) 10.

<sup>333</sup> The President reappointed the Ministers that had been censured by the Parliament in 1998. Daily Monitor “Muhwezi censure hangs in balance” (11-9-2005) 2.

#### 4.4 LACK OF AWARENESS OF THE RIGHT TO ACCESS ESSENTIAL TREATMENT

All the key informants, including the MoH, mentioned the lack of awareness of the population on the possibility of being treated as one of the major barriers to access to essential treatment. Indeed, the efforts of the government seem to focus mainly on prevention, with almost no information regarding the centres providing essential treatment, the cases in which ARV therapy is recommended, or the benefits and risks such a treatment could provide to PLWHA.

In addition, the relevance of the right to health and its impact with regard to the provision of essential treatment seems immaterial for the majority of the informants. It is obvious that the right to information and to HR-education are being violated and this is a major obstacle for the right to essential treatment to be realised.

#### 4.5 ARMED CONFLICT IN NORTHERN UGANDA AND ITS EFFECT ON ACCESS TO ESSENTIAL TREATMENT

The insurgency of the Lord's Resistance Army (LRA) in Northern Uganda has significantly contributed to the spread of HIV/AIDS in the region. Sexual assault, as well as the behavioural change due to interruption of social networks and economic vulnerability,<sup>334</sup> rendered this area one with the highest HIV/AIDS prevalence rates in the country.<sup>335</sup>

The provision of essential treatment in this area is highly disrupted by the conflict, rendering it difficult for the government to supply the HIV-health centres due to security reasons.<sup>336</sup> Surprisingly, there is only one centre providing ARVs in the northern region, but the government is liaising with WHO and MSF to extend ART to a larger group of people.<sup>337</sup> Though admittedly difficult, the government should not rely on security arguments to justify the absence of attention on the population in the North, as it is bound internationally to provide medical care to sick people "to the fullest extent practicable and with the least possible delay".<sup>338</sup> This includes not only civilians but also rebels. The availability of treatment could eventually act as an inducement for combatants to stop fighting.<sup>339</sup>

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<sup>334</sup> UNAIDS, Fact Sheet No.2 "HIV/AIDS and conflict", <[http://www.unaids.org/html/pub/Topics/Security/FS2conflict\\_en\\_doc.htm](http://www.unaids.org/html/pub/Topics/Security/FS2conflict_en_doc.htm)>(accessed 12-9-2005).

<sup>335</sup> Interview at MoH (above n. 173).

<sup>336</sup> As above.

<sup>337</sup> As above.

<sup>338</sup> Art.7, Protocol Additional to the Geneva Conventions and Relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II).

<sup>339</sup> International Crisis Group (ICG) "HIV/AIDS as a Security Issue in Africa: Lessons from Uganda" (2004) 3 *ICG Issues Report*, 12.

The HIV/AIDS prevalence rate among the Uganda People's Defence Force (UPDF) is estimated to be around 20 percent.<sup>340</sup> Local sources indicate that soldiers are also perpetrators of sexual abuse in the region<sup>341</sup> and, therefore, their presence also contributes to the spread of the disease. Soldiers diagnosed with HIV/AIDS must leave military service.<sup>342</sup> Such measure is highly regrettable, since it increases stigmatisation and prevents disclosure and control of the disease.

#### **4.6 GENDER RELATIONS AS A BARRIER TO ACCESS TREATMENT**

As indicated by HRW, cultural perceptions of women's sexual and reproductive obligations deprive them of bodily autonomy.<sup>343</sup> This factor, together with male-dependency and poverty, render women particularly vulnerable to the pandemic.

Particularly with regard to rural women, the multiple tasks they undertake impede them to get the time to take care of their health status. The fact that ARV-centres have not yet reached the rural areas further diminishes the possibility of being treated, since this adds more time and transport costs to the mere consultation.<sup>344</sup> In addition, the male-dependency on any decision impedes women to go for treatment, since this implies not only revealing their HIV-status, with the consequent rejection of family and social environment, but also being victims of violence.<sup>345</sup>

#### **4.7 CONCLUSION**

This chapter demonstrates that many socio-political as well as economic factors may influence the provision of essential treatment in Uganda. In addition to the government, various non-state actors influence the decisions taken with regard to essential treatment, and their degree of responsibility should also be measured against their HR obligations. On the other hand, the response of the government seems to be short of the same political will demonstrated with regard to HIV/AIDS prevention, and this shows another reality behind the apparent success story of Uganda with regard to HIV/AIDS.

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<sup>340</sup> As above, 6.

<sup>341</sup> Human Rights Watch (HRW) "Uprooted and forgotten: Impunity and human rights abuses in Northern Uganda" (2005) 24.

<sup>342</sup> ICG (above n.339) 9.

<sup>343</sup> HRW, "Just die quietly: domestic violence and women's vulnerability to HIV/AIDS" (2003) 21.

<sup>344</sup> As above.

<sup>345</sup> HRW (above n.343) 2.

## **CHAPTER FIVE**

### **CONCLUSIONS AND RECOMMENDATIONS**

#### **5.1. CONCLUSIONS**

##### **5.1.1. SCOPE OF ACCESS TO ESSENTIAL TREATMENT FOR PLWHA UNDER INTERNATIONAL LAW**

Access to essential treatment for PLWHA has been clearly identified as a right within the international HR framework. By contrast to the majority of socio-economic rights, this right is non-derogable, and constitutes one of the core aspects of the right to health that the state of Uganda must satisfy, whatever its stage of economic development. The state of Uganda remains liable at international level for any violation of this right, despite the fact that it has not incorporated the international HR agreements that it ratified into its national legal order and it has not expressly recognised this right in its Constitution.

The international obligation of the state is tripartite and involves the duty to respect, protect and fulfil the right to access to essential treatment. Non-state actors have also undertaken obligations with regard to this right at international level and their interaction in the fulfilment of the right at stake is important in order to measure the response that needs to be adopted from a HR-perspective.

##### **5.1.2. IMPLEMENTATION OF THE RIGHT TO ACCESS ESSENTIAL TREATMENT IN UGANDA**

Although the state of Uganda has already met the target set up by UNAIDS to provide ART to 60,000 people by the end of 2005, a closer look at the constitutional, legislative, policy and judicial framework indicates that the State has not made every effort to realise this minimum core obligation for the whole population in need.

First of all, the right to health is deprived of the same protection guaranteed to other rights in the Constitution, by being relegated to its NODPSP with the intention to render it unenforceable. Secondly, the HIV/AIDS pandemic in general, and the right to access essential treatment in particular, have been completely ignored within the legislative framework, making it difficult to render it justiciable. Thirdly, the state has failed to provide a comprehensive NHP with effective mechanisms of implementation. On the contrary, access to essential treatment is dealt with in numerous policies that are short of an implementation strategy and accountability mechanisms. In view of this weak legal basis, it is not surprising that the jurisprudence has not paid too much heed to the right to health or its minimum threshold. Finally, the inefficient management of funds, and the evidence of “serious

mismanagement” with regard to the GF’s grants, clearly indicates that the government is far from making every effort to satisfy the right of PLWHA to essential treatment.

The provision of ARVs by the civil society has effectively discharged the government of much of the burden implicit in the provision of access to essential treatment. Advocacy from a HR-perspective is, however, weak and this perpetuates the myth of considering the government as a provider of goods and services, rather than a duty-bearer of the rights of individuals.

A cursory look at the activity of donors and international organisations indicates that, quantitatively, they have been forthcoming in their contributions, but qualitative, there is a lack of coordination that renders this aid less effective.

### **5.1.3. OBSTACLES TO THE REALISATION OF THE RIGHT TO ACCESS ESSENTIAL TREATMENT IN UGANDA**

An analysis of the obstacles to the realisation of access to essential treatment reveals the major role played by globalisation in the government’s strategy to tackle access to essential treatment. Lack of commitment and good governance also had a major impact on the efficiency of the government’s response, and the perceived lack of knowledge of the population with regard to the existence of HIV-drugs indicates that the rights to access HIV-information and education are being violated.

The political conflict in the North has greatly contributed to the spread of the disease as well as to the difficulties in providing essential treatment in this region. Finally, the strong influence of patriarchy social conceptions with regard to the role of women in the Ugandan society, has served as a deterrent to seek treatment among the women affected.

## **6.1. RECOMMENDATIONS**

### **6.1.1. RECOMMENDATIONS FOR THE GOVERNMENT**

#### **6.1.1.1. Legislative measures**

The inclusion of the right to health in Chapter Four of the Constitution could clarify any doubts regarding its contestable justiciability. It could also encourage public interest litigation with regard to this right, since a clear legal basis provides more chances for cases to succeed before courts.

In addition, national legislation should be adopted imposing on the government the obligation to make every effort to use all available resources, including those of the international community, in an effort to satisfy, as a matter of priority, the right to access to essential treatment for the population in need.

The government should be obliged to put mechanisms in place that will guarantee the geographic accessibility of the drugs, particularly in neglected areas. In addition, criteria should be developed to determine the category of people that could have access to free drugs, subsidised drugs or pay drugs. The government should be made liable to seek a rapid and sustainable solution for the provision of essential treatment to population living in conflict areas. Efforts should be made to negotiate humanitarian arrangements, similar to the “days of tranquility” first employed in El Salvador in 1985,<sup>346</sup> to allow combatants and civilians to access to essential treatment in health centres, in cooperation with international organisations. The law should also impose on the government the immediate obligation to inform the population of the possibility of obtaining essential treatment and the benefits ART brings to PLWHA. The possibility of challenging the implementation of the law before the courts should also be foreseen.

New legislation regulating pharmaceuticals should also be adopted, merging the various statutes that touch upon drug issues. Tighter measures should be provided with regard to essential medicines, particularly those treating epidemics, as foreseen in the National EML, whose periodical update should be established by law taking into account WHO’s recommendations.<sup>347</sup> This legislation should focus on avoiding the frequent and long stock outs in hospitals, imposing the obligation on health units to keep accurate records that should be reported periodically to the MoH.<sup>348</sup> Moreover, all the drugs should be kept in sufficient quantity in the healthcare units, and a rigorous system of control should be imposed in order to avoid their diversion. The law should also impose routine inspections<sup>349</sup> both in public and private facilities, and an accountability mechanism should be foreseen in order to monitor compliance.<sup>350</sup>

The Industrial Property Bill should impose on the government the obligation to make every effort to promote the development of a local pharmaceutical industry. In addition, it should also facilitate the use of compulsory licences to be issued at national level or at the request of foreign countries. The Bill should also ensure that the possibility of importing generic drugs is not restrained.

The provisions contained in the Venereal Diseases Act and the Public Health Act providing for restrictive measures should be repealed and be substituted for a general clause allowing their use insofar as they are proportionate to the aims pursued.

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<sup>346</sup> ICG (above n.339) 12.

<sup>347</sup> At the moment this is only established in the NDP (above n.201).

<sup>348</sup> As required in the ATP, (above n.190).

<sup>349</sup> As above.

<sup>350</sup> Eg disciplinary measures for hospitals or practioners found to keep continuous irregularities in their files.

### **6.1.1.2. Administrative measures**

The government should engage into a revision of the existent national policies regarding HIV/AIDS, bearing in mind their HR implications. The long-term needs of the country should be converted into targets in the policies, and a timetable should be established for their completion, which should be monitored through the use of benchmarks and indicators. A periodic audit of the policies should also be foreseen, as well as an accountability mechanism to render the ministries affected liable for their performance. In addition, the distribution of international funds should be based on public tenders, whose requirements follow principles of non-discrimination.

The adoption of mechanisms to ensure the sustainability of the provision of essential treatment should be established as a matter of urgency. A thorough study should be carried out comparing the mechanisms of sustainability established in other African countries (for example, the establishment of a HIV/AIDS duty in Zimbabwe), and bearing in mind the capacity of the Ugandan population to bear the costs according to their economic power. These measures should be accompanied by an increase of the budgetary health allocations of the government to provide access to essential treatment. The government of Uganda should resist the pressures of the IFIs, particularly bearing in mind that this increase will be used for top priority spending.

The PEAP should take into consideration the interlink between HIV/AIDS and poverty, as well as other variants, like gender, and balance the cost implications of providing essential treatment against its impact on the overall economy.

The government should make use of the flexibilities established in the current Patent statute in order to openly import generic drugs up until the Industrial Property Bill is adopted.

The promotion of information campaigns on essential treatment is equally important, since they will serve as a measure of control of the disease, encouraging people to get tested, and as a way of increasing productivity at the work place and reducing the number of medically-ill patients in the already overcrowded hospitals.

### **6.1.1.3. Judicial protection**

Following the excellent precedents of *TEAN* and *Tinyefuza*, and looking at the creative interpretations given in other jurisdictions, Ugandan courts should be encouraged to adjudicate on the right to access to essential treatment by referring to its link to various other rights.

The resource constraints faced by the government in fulfilling this right are not negligible and should not be overlooked by the judiciary. However, justiciability should be a way of controlling how the

available resources are being prioritised and spent. Bearing in mind the public purpose of containing HIV/AIDS and the cost-benefits of the provision of ART, the government's inefficient use of resources needs to be reviewed in order to provide the right-holders, particularly those most disadvantaged, their minimum entitlements.

These recommendations are equally valuable for the UHRC, whose flexibility in proceedings makes it an ideal forum to bring matters by those affected. In addition, the UHRC should better utilise its quasi-judicial powers to render the government accountable with regard to the right to essential treatment.

## **6.1.2. RECOMMENDATIONS TO NON-STATE ACTORS**

### **6.1.2.1. Recommendations to the international organisations and the donor community**

With regard to the IFIs, it should be noted that, despite being limited by their mandate to economic matters,<sup>351</sup> they have broadened it to good governance issues, and, as UN agencies, they are obliged to promote the HR mission, in cooperation with other agencies. In order to tackle poverty, the IFIs should first insist on the participation of the most vulnerable in the solutions of which they are the targets. Moreover, the fight against HIV/AIDS requires budgetary implications and life-saving measures that cannot be sacrificed in the name of economic stability.

With regard to third states, it is essential that developed countries empower LDCs with the tools that could diminish their technological and economic dependence on Western economies. In addition, a firm commitment towards the eradication of prejudicial practices that are against the spirit of cooperation of the UN Charter, should be abided by at UN level.

### **6.1.2.2. Recommendations to the civil society**

There is an urgent need for the civil society, not only to assist in the provision of ARVs, but also to advocate for it and to be the voice of disadvantaged groups that are not aware of their rights.

In addition, civil society should take the opportunity to engage in public interest litigation regarding access to essential treatment. This has been shown very successful in other countries, as demonstrated by the *TAC* case. Bringing matters in the framework of an organisation will enable PLWHA to deal with the costs and technicalities normally implicit in judicial suits.

**WORD COUNT: 17,953**

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<sup>351</sup> Art.IV para.3(b) of the Agreement of the IMF, (1945) 2 UNTS 39.



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## APPENDIX A

### INTERVIEW GUIDE FOR MANAGERS IN HIV/AIDS TREATMENT CENTRES

**Name of the organisation:**

**Name of the representative:**

**Title:**

**Date:**

**Time:**

**Place:**

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#### PROVISION OF ESSENTIAL DRUGS WITHIN THE POLICY FRAMEWORK

1. On what law/policy do you based yourself to provide anti-retroviral treatment (ART)/treatment of opportunistic infections (TOI)?
2. Do you have any views regarding the resources allocated to health expenditure in general and to the anti-retroviral (ARV) policy in particular?
3. Is there any procedure in place to protect the rights of volunteers in medical trails testing the effects of new HIV drugs?
4. Regarding sources of supply:
  - a. What is the source of supply of your drugs, the National Medical Stores (NMS) or private?
  - b. Are the drugs sufficient for all the PLWHAS you treat?
  - c. What are your views regarding delivery of the drugs?

#### For public facilities

5. When determining who should have priority access to ART:
  - a. Is the economic situation of the person in need being taken into consideration?
  - b. How do you determine who should have free-of charge or subsidised access to ART?
6. What percentage of your patients is acceding free-of-charge drugs, subsidised drugs and full price drugs?
7. Do you provide your patients information on different cheap drugs?

8. What are your views with regard to the governmental ARVs policy, in terms of geographic distribution, tackling vulnerability aspects, and the lack of resources of the people in need?
9. Have the following groups at risk any preferential access to ARVs: sexual workers, adolescents, rural women that were not part of MTCT programmes?

**For private facilities**

10. Do you follow any rules to provide preferential access to ARVs to certain target groups?
11. If so, which rules?
12. Do you obtain any funds to subsidise the price of ARVs you provide?
13. Are you subject to any control with regard to:
  - a. the prices you charge for essential drugs;
  - b. information on stock status and consumption;
  - c. resistance and toxicity of drugs?
  - d. Adequacy of the infrastructure and human resources for the provision of ARVs?
14. Do you provide your patients information on different cheap drugs?

**APPLICATION OF THE POLICY**

15. In your opinion, what are the socio-economic factors that impede access to essential treatment in Uganda?
  - a. Poverty;
  - b. Lack of infrastructure and personnel;
  - c. Insufficient budget allocations;
  - d. Trade-related obligations;
  - e. Other
16. What are the reasons given by your patients for lack of adherence?
  - a. Lack of resources;
  - b. Difficult compliance;
  - c. Lack of support;
  - d. Other

## APPENDIX B

### INTERVIEW GUIDE FOR NON-GOVERNMENTAL ORGANISATIONS

**Name of the organisation:**

**Name of the representative:**

**Title:**

**Date:**

**Time:**

**Place:**

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#### STATISTICS

1. On which statistics do you rely to determine the prevalence rate of HIV/AIDS in Uganda?
2. Accuracy of prevalence rates:
  - a. What are your views regarding the accuracy of the official HIV/AIDS prevalence rates in Uganda?
  - b. What are the factors, according to you, that could affect the accuracy of the HIV/AIDS prevalence rates in Uganda?

#### HEALTH BUDGET

3. Do you have any views regarding the resources allocated to health expenditure in general and to the ARV policy in particular?
4. What are your views regarding the decision of Global Fund to freeze the funds designated to Uganda?

#### RIGHT TO HEALTH

5. What are your views regarding the health provisions in the Constitution and their impact on the protection of the right to health?
6. Justiciability of the right to health:
  - a. Has your organisation ever consider bringing an action regarding the protection of the right to health of PLWHAS?
  - b. Please explain the reasons for bringing such an action or disregarding that possibility.

## **PROVISION OF ESSENTIAL DRUGS WITHIN THE LEGAL SYSTEM**

7. According to my research there is no legislative measure regulating the supply of ART or treatment of OI in Uganda.
  - a. Please explain why do you think this is the case.
  - b. Do you think the enactment of laws in this area could be a positive move?

## **INTERNATIONAL TRADE OBLIGATIONS**

8. Are you aware of the patent issues regarding access to drugs?
9. If so, what are your views regarding the use by the government of the flexibilities provided in TRIPS?
10. Do you have any views with regard to the Industrial Property Bill?

## **PROVISION OF ESSENTIAL DRUGS WITHIN THE POLICY FRAMEWORK**

11. What are your views with regard to the ARVs policy, in terms of:
  - a. geographic distribution;
  - b. tackling vulnerability aspects;
  - c. the lack of resources of the people in need?

## **APPLICATION OF THE POLICY**

12. In your opinion, what are the socio-economic factors that impede access to essential treatment in Uganda?
  - a. Poverty;
  - b. Lack of infrastructure and personnel;
  - c. Insufficient budget allocations;
  - d. Trade-related obligations;
  - e. other
13. Has your organisation identified any retrogressive measure? (Eg People were provided with ARVs before and not any more, clear prohibitions to provide ARVs to certain people or to provide a particular drug that has been proved to be safe and efficient?)
14. Could you please comment on the situation of the following groups at risk and the respective response given by the government with regard to access to ARVs?

- a. Exposure to HIV through sexual assault. Are the victims of sexual assault automatically informed of the possibility of preventing the infection through the intake of ARVs?
- b. Rural women that have not participated in MTCT programmes;
- c. Adolescents;
- d. Prisoners;
- e. Sexual workers that have not participated in MTCT programmes;
- f. IDPs
- g. Illegal immigrants.

15. Are you aware of any discriminatory practices in the provision of treatment to PLWHAS at the healthcare facilities?

16. Are you aware of experimentation with new drugs on people without their consent?

17. Safety of the drugs:

- a. What are your views regarding safety of the drugs in Uganda?
- b. What are your views regarding the role of the NDA in this respect?

18. What are your views regarding the information provided in health centres with respect to:

- a. explanations on the benefits and risks of treatment,
- b. information about the different types of drugs and their prices?

## APPENDIX C

### INTERVIEW GUIDE FOR POLICY MAKERS

**Name of the organisation:**

**Name of the representative:**

**Title:**

**Date:**

**Time:**

**Place:**

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#### HEALTH BUDGET

1. Health budget:
  - a. Could you please comment on the trend followed by the national health budget through the last five years (ex. increase, decrease, still)?
  - b. Would you be able to provide an indication of the proportion of the gross national product (GNP) that this budget represents for this year?
  - c. Are you aware of the percentage allocated for primary and for tertiary health?
2. Budget allocated for ART and TOI:
  - a. Would you be able to comment on the trend followed by the national budget allocated for ART and OI through the last five years (ex. increase, decrease, still)?
  - b. Would you be able to provide an indication of the proportion of the health budget that the budget for ART and OI represents for this year?

#### PROVISION OF ESSENTIAL DRUGS WITHIN THE LEGAL SYSTEM

3. What are your views regarding the health provisions in the Constitution and their impact on the protection of the right to health?
4. According to my research there is no legislative measure regulating the supply of ART or treatment of OI in Uganda.
  - a. Please explain why do you think this is the case.
  - b. Do you think the enactment of laws in this area could be a positive move?
5. Are there any plans to merge and/or update the various statutes pertaining to public health or to the provision of drugs?

## **INTERNATIONAL OBLIGATIONS**

6. What is the impact of the international human rights provisions and the interpretation given by the monitoring mechanisms in the process of drafting HIV/AIDS related policies?
7. Are you aware of the patent issues regarding access to drugs?
8. If so,
  - a. What is the impact of the WTO trade obligations of Uganda in the process of drafting HIV/AIDS related policies?
  - b. What is the impact of health issues on the drafting of patent laws in Uganda?

## **PROVISION OF ESSENTIAL DRUGS WITHIN THE POLICY FRAMEWORK**

9. What are the main policies regarding access to ARVs currently in force?
10. When determining who should have priority access to ART,
  - a. Is the economic situation of the person in need being taken into consideration?
  - b. How do you determine who should have free-of charge or subsidised access to ART?
  - c. Is the proximity to the healthcare facilities of the people in need one of the factors that determines the geographic distribution of ARVs?
  - d. Were the higher HIV/AIDS prevalence areas given priority access?
  - e. Are there any specific provision tackling the following groups: Sexual workers, prisoners, rural women not part of a MTCT programme, adolescents?
11. Do you know what percentage of the population is accessing free-of-charge drugs, subsidised drugs or drugs from public/private centres?
12. Are there any mechanisms in place to encourage the sustainable financing of drugs?
13. Are there any measures in place to improve the procurement of drugs in the public sector?
14. Are there any guidelines in place determining when to buy generic or branded drugs?
15. In the private sector,
  - a. Is there any mechanism in place to monitor resistance and toxicity of drugs?
  - b. Is there any mechanism to monitor prices?
16. Are there any mechanisms to enforce compliance with the policies in the public and private sectors?



## **APPLICATION OF THE POLICY**

17. In your opinion, what are the socio-economic factors that affect access to essential treatment in Uganda?

- a. Poverty;
- b. Lack of close health-related facilities and personnel;
- c. Insufficient budget allocations;
- d. Trade-related obligations;
- e. Other