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Protection against Gender Based Violence and Litigation for HIV related Rights

A Handbook for Lawyers and Activists

October 2018

IDLO

Creating a Culture of Justice

International Development Law Organization

for Girls & Women

POSITIVE ACTION

Protection against Gender Based Violence and Litigation for HIV related Rights, A Handbook for Lawyers and Activists.

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FOREWORD

Recognizing the need for urgent action, Determined, Resilient, Empowered, AIDS-free, Mentored and Safe Initiative (DREAMS), an ambitious $385 million partnership, has invested $85 million to support innovative solutions from 56 organizations, among them the International Development Law Organization (IDLO), to infuse new thinking and approaches to meet the urgent, complex needs of adolescent girls and young women (AGYW).

IDLO, partnered with the Center for Health, Human Rights and Development (CEHURD) to implement a project which aims to strengthen the capacity of AGYW and their communities to hold service providers accountable for the delivery of quality HIV and sexual reproductive health related services in Uganda. This project focuses on the legal and social drivers affecting AGYW and the communities' ability to keep HIV service providers accountable in Uganda, specifically in the districts of Gomba and Mukono. With an innovative blend of legal empowerment and social accountability strategies (LE/SA+) at national, district and local levels, the project has been able to target the drivers of accountability and gender inequality upon which challenges continue to thrive.

Through the implementation of this project, we noted that when HIV, sexual reproductive health and gender based violence initiatives invoke the law and rights-based language, this is typically limited to providing people with very basic HIV and health education, very few actually work to empower communities and individuals through a discussion of their rights and entitlements, and the processes for claiming them and legally addressing sexual violence through the courts of law.

This hand book comes in as a contribution towards assisting human rights lawyers and activists to pursue legal remedies for survivors of HIV and AIDS human rights related violations and abuses. It is also our sincere hope that the handbook will aid survivors of gender-based violence (GBV) in pursuing litigation and other legal avenues as part of the justice process.

Lastly, we would like to extent our sincere gratitude to the International Development Law Organization (IDLO) and the Positive Action for Girls and Women for the great collaboration.

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Mulumba, Moses
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This handbook was researched and written by Prof. Christopher Mbazira - Principal, School of Law Makerere University, Nakibuuka Noor, Wasswa Paul, Kabanda David, Nakanwagi Gertrude and Mulumba Moses – CEHURD all provided leadership and co-ordinated the manual writing process. David Patterson, Barbara Kawira Japan and Charles Karari - IDLO all provided useful comments on the draft.

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Technical editing was provided by Maurice Oduor.

CONTENTS

LIST OF ACRONYMS

AIDS	-	Acquired Immune Deficiency Syndrome
AGYW	-	Adolescent Girls and Young Women
ART	-	Antiretroviral Therapy
CEHURD	-	Center for Health, Human Rights and Development
CSOs	-	Civil Society Organisations
DPP	-	Directorate of Public Prosecutions
EMTCT	-	Elimination of mother-to-child transmission of HIV
EOC	-	Equal Opportunities Commission
ESCR	-	Economic, Social and Cultural Rights
GBV	-	Gender based Violence
HIV	-	Human Immune Virus
HAPCA	-	HIV and AIDS Prevention and Control Act
HRBA	-	Human Rights Based Approach
ICESCR	-	International Covenant on Economic, Social and Cultural Rights
IDLO	-	International Development Law Organization
LE	-	Legal Empowerment
NODPSP	-	National Objectives and Directive Principles of State Policy
PEP	-	Post-exposure prophylaxis
PrEP	-	Pre-exposure prophylaxis
PIL	-	Public Interest Litigation
SA	-	Social Accountability
SAA	-	South African Airways
GBV	-	Sexual and Gender Based Violence
SRHR	-	Sexual Reproductive Health and Rights
STIs	-	Sexually Transmitted Infections
TAC	-	Treatment Action Campaign
UHRC	-	Uganda Human Rights Commission
UNCESCR	-	United Nations Committee on Economic, Social and Cultural Rights
UNAIDS	-	The Joint United Nations Programme on HIV and AIDS
UNDP	-	United Nations Development Programme
WHO	-	World Health Organisation

DEFINITION OF TERMS

Discrimination is used to mean actions or omissions that are derived from stigma and directed towards those individuals who are stigmatized. Discrimination, as defined by UNAIDS (2000) in the Protocol for Identification of Discrimination Against People Living with HIV, refers to any form of arbitrary distinction, exclusion, or restriction affecting a person, usually but not only by virtue of an inherent personal characteristic or perceived belonging to a particular group.

Domestic Relationship is used in the Domestic Violence Act to mean "a family relationship, a relationship similar to a family relationship or a relationship in a domestic setting that exists or existed between a victim and a perpetrator".

Domestic Violence as used in the Domestic Violence Act constitutes any act or omission of a perpetrator which - (a) harms, injures or endangers the health, safety, life, limb or well-being, whether mental or physical, of the victim or tends to do so and includes causing physical abuse, sexual abuse, emotional, verbal and psychological abuse and economic abuse; (b) harasses, harms, injures or endangers the victim with a view to coercing him or her or any other person related to him or her to meet any unlawful demand for any property or valuable security; (c) has the effect of threatening the victim or any person related to the victim by any conduct mentioned in paragraph (a) or (b) (c) or (d) otherwise injures or causes harm, whether physical or mental, to the victim.

Legal Empowerment (LE) is an approach that refers to initiatives that strengthen the capacity of disadvantaged individuals and communities to understand, access and exercise their rights in a way that enables them to control their lives and/or influence changes in law and policy.

Post-Exposure Prophylaxis (PEP) as defined by the World Health Organization (WHO) is a short – term anti-retroviral treatment to reduce the likelihood of HIV infection after potential exposure, either occupationally or through sexual intercourse. It is administered within 72 hours of exposure.

Pre-Exposure Prophylaxis (PrEP) as defined by the World Health Organisation (WHO) is the use of an antiretroviral medication by uninfected persons to prevent HIV infection.

Prosecution is used to mean all procedures involved in pursuing a case either a criminal or civil court for the purposes of obtaining relief for a victim.

Public Interest Litigation (PIL) is used to refer to court action which is designed to pursue the public good and deal with violations and abuses that affect the public or a big number of people or has the potential to harm the public interest. Such litigation could be intended to change social norms or laws and policies.

Remedies is used to mean all types of relief a person who has suffered a human rights violation can obtain either from judicial or quasi-judicial bodies. It could also include administrative reliefs as well as reliefs obtained from international courts and tribunals.

Social Accountability (SA) is a governance approach that promotes civic engagement, empowerment and access to better services by including citizens and civil society organisations in public decision making.

Stereotypes is used to mean widely but fixed and oversimplified images or ideas of a particular type of person or thing. Such views could be held with respect to persons affected by HIV and AIDS, survivors of GBV, among others.

Stigma means a dynamic process of devaluation that 'significantly discredits' an individual in the eyes of others. The qualities to which stigma adheres can be quite arbitrary - for example, skin colour, manner of speaking, or sexual preference, perceived or real HIV status.

Structural Injunction is a type of injunction which enables the court, after hearing a matter and making an order, to retain jurisdiction to oversee the implementation of its order.

PART I

INTRODUCTION

This Handbook is designed to assist human rights lawyers and activists pursue remedies for survivors of HIV and AIDS human rights related violations and abuses, as well as for survivors of gender-based violence (GBV) in Uganda. The Handbook is intended to provide advocates and activists with information on the laws that can be used to pursue the remedies. The Handbook was developed as part of activities under a project entitled: Integrating Legal Empowerment and Social Accountability for Quality HIV Health Services for Adolescent Girls and Young Women, implemented by the Center for Health, Human Rights and Development (CEHURD) and the International Development Law Organisation (IDLO). The project addresses systemic inequalities and obstacles to health service access and responses to GBV with a view to influencing systemic improvements for the benefit all AGYW in the country.

The project is designed to benefit AGYW and members of their communities in two ways. First, it seeks to improve processes such as local grievance and justice processes, established lines of feedback, and existing legal aid services. Secondly, the project aims to improve the capacity of providers of justice services to more effectively deploy the services in favour of AGYW.

Solutions provided by the project target the legal and social factors affecting provision of HIV and GBV related services to AGYW. The project deploys a combined legal empowerment and social accountability approach (LE/SA+), to tackle the problem of lack of accountability among service providers (poor governance) as well as gender inequality. These two challenges have proven to be the base upon which other AGYW challenges thrive, including: lack of information about HIV and related risks; inability to refuse or negotiate safe sex; lack of access to PreP; lack of access to health services such as HIV testing and counselling services; and gender- based violence. The two challenges are in turn compounded by other factors such as poverty and lack of education.

In the last ten years, litigation focused on human rights has increased in Uganda. That period has seen marked improvement not only in the knowledge and appreciation of the language of rights but also, in the skills and strategies used in litigating human rights cases. Both the bench and the bar have increasingly been willing to engage critically and more effectively with cases touching on human rights. While early cases mainly addressed civil and political rights issues such as equality and freedom of expression, recent litigation has started to address economic, social and cultural rights, with the most prominent among those being the right to the highest attainable standard of physical and mental health. This has arisen mainly from activism, research and litigation by CSOs in collaboration with legal academics. For instance, CEHURD has been very instrumental in contributing to the development of the law on reproductive health rights and access to health care services through cases such as; *Center for Health, Human Rights and Development & Ors v Attorney General* (Petition 16 of 2011), *Center for Health, Human Rights and Development & Ors v*

Attorney General (Constitutional Petition No. 64 of 2011), and *Center for Health, Human Rights and Development & Ors v Nakaseke District Local Administration* (High Court Civil Suit No. 111 of 2012).

Even though Uganda has had a long history with HIV and AIDS, there has been limited litigation on this area of law. This could be explained by the fact that majority of CSOs working on HIV and AIDS have largely focused on service provision and awareness creation. As they become more acquainted with the human rights-based approach (HRBA) to dealing with HIV and AIDS, Ugandan CSOs are increasingly deploying human rights as part of their operational strategies. This development is made more significant in the background of new knowledge generated by organisations such as the UN which link the prevalence of HIV and AIDS to human rights violations, particularly in the context of AGYW.[1] For example, lack of legal empowerment among AGYW has been found to be a factor that exacerbates GBV, which in turn influences sexual behaviour and decision-making.[2] A HRBA is also important because Uganda has, as a state, decidedly adopted a mulltisectoral thrust that incorporates law as part of the response to the problem of HIV and AIDS. It is then necessary that CSOs, and other participants involved in rights protection in the context of HIV and AIDS, be equipped with knowledge and skills as will enable them to effectively deploy the tools that have been availed by the law This handbook therefore seeks to identify the key legal rules and processes that can be used to intervene in situations of violations of rights of PLHIV, with the focus being on AGYW. The handbook seeks to equip users with practical knowledge on how to lodge and move cases dealing with HIV and AIDS as well as GBV. The ultimate goal is that continued use of the handbook will result in increased social accountability among institutions and providers of services related to HIV and AIDS and GBV, particularly as they affect AGYW.

1.1. Aim and Objectives of Handbook

The overall aim of the handbook is to promote legal empowerment by enhancing the skills of human rights lawyers and activists in pursuing remedies for survivors of HIV and AIDS related violations/abuses as well as obtaining relief for survivors of GBV while promoting social accountability. The specific objectives of the handbook include the following:

(a) *To highlight the connection between HIV and AIDS, human rights and GBV;*

(b) *To provide lawyers and activists with information and sources of law they can use in pursuing remedies for survivors of HIV and AIDS human rights violations/abuses and those of GBV; and*

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[1] See UNAIDS and African Union Empower Young Women and Adolescent Girls: Fast-Tracking the End of the AIDS Epidemic in Africa (2015).

[2] See Janet Fleischman and Katherine Peck Addressing HIV Risk in Adolescent Girls and Young Women Center for Strategic & International Studies (2015)

(c) *To enhance the skills of lawyers involved in public interest litigation of HIV and AIDS and GBV cases*.

1.2. Summary of Handbook

The Handbook is divided into eight parts as is indicated below.

Part I: Introduction

The foregoing materials constitute the introduction.

PART II: Understanding HIV and AIDS, GBV and their connection

This Part provides some basic facts on HIV and AIDS, situates HIV and AIDS in the context of gender, and highlights the link between GBV and HIV and AIDS among AGYW. It achieves this by including excerpts from different sources detailing this information. The excerpt from the World Health Organisation HIV/AIDS Fact Sheet, gives summary information on the nature of HIV, the meaning of AIDS, symptoms, transmission,, risk factors, diagnosis, testing, prevention and treatment. The excerpt from The Joint United Nations Programme on HIV and AIDS titled: HIV Prevention among Adolescent Girls and Young Women: Putting HIV Prevention Among Adolescent Girls and Young Women on The Fast-Track and engaging Men and Boys, contextualises HIV and AIDS among AGYW. It details the special predisposition of AGYW to HIV infection as defined by behavioural, biological and structural factors. Finally, it tackles the link between GBV and HIV among AGYW.

PART III: HIV and AIDS, GBV and the Right to Health and the Law in Uganda

Part III highlights Uganda law in relation to the right to health, HIV and AIDS and GBV. In the Constitution, the right to health is implicit in several provisions, including those in the Bill of Rights that touch on some elements of the right. However, most of the elements are to be found in the National Objectives and Directive Principles of State Policy. GBV is dealt with through provisions which guarantee the right to dignity and the prohibition of torture, inhuman or degrading treatment or punishment. So are provisions on equality between men and women and those which prohibit negative customary practices. The equality provisions are also relevant in dealing with HIV and AIDS discrimination. This part also introduces the HAPCA, 2014 as well as the Domestic Violence Act, 2010.

PART IV: The Legal Issues Related to HIV and AIDS and GBV

Part IV highlights the legal issues that relate to HIV and AIDS and GBV, defining possible causes of action in various contexts, including in areas of discrimination, access to medicines, reproductive health rights, privacy and GBV. Discrimination is conceived of in a broad form to encapsulate discrimination in education, access

to health care, access to public services, travel and habitation as well as access to credit and insurance. The relevant laws are illustrated, as well as court cases which have dealt with some of the issues. The part also deals with jurisdiction related issues, especially in constitutional matters.

PART V: Case Selection and Preparation

PartV is designed to enhance the skills of activists and advocates in case selection and preparation. It explains in a practical manner the factors that lawyers need to consider when deciding whether or not to litigate a matter, choosing a litigation strategy, how to factor in resources and time in research and preparation, defining an advocacy plan, collecting evidence, among other steps.

PART VI: Question of remedies

This part demonstrates the importance of remedies and provides guidance on the different forms of judicial remedies that may be available to survivors of HIV & AIDS and GBV related violations. The part illustrates circumstances under which the remedies of declarations, damages and injunctions may be utilised. Particular regard is paid to a fairly recent remedy, that of the structural injunction, that is currently gaining ground in human rights litigation, and which allows a court to supervise the implementation of its order, post-judgment. The part also gives a snapshot of mechanisms at the African regional level through which remedies may be pursued, including in the African Commission on Human and Peoples Rights and the African Court on Human and Peoples Rights.

1.3. Style of the Handbook

The style adopted is intended to ensure that the handbook is as practical and as user-friendly as possible. In the first place, the handbook draws on existing manuals on litigation. These include the CEHURD Manual titled: *Litigating Maternal Health Rights: What Civil Society Groups must Know* as well as the Public Interest Law Clinic's manual entitled: *Economic, Social and Cultural Rights Litigation in Uganda: A Manual for Public Interest Lawyers and Litigators.* Excerpts are drawn from these manuals, as well as from other relevant sources, including international instruments, national legislation and court decisions. This handbook does not seek to be exhaustive on issues relating to litigation of HIV and AIDS and GBV related issues.

PART II

UNDERSTANDING HIV & AIDS AND GBV AND THEIR CONNECTION

2.1. HIV Epidemiology

The materials excerpted here provide basic knowledge on HIV and AIDS including the nature of HIV, its transmission, its prevention, and its management. Those who provide HIV related legal services must have this basic information if they are to communicate effectively.

World Health Organisation HIV/AIDS Fact Sheet,
available at http://www.who.int/mediacentre/factsheets/fs360/en/

The Human Immunodeficiency Virus (HIV) targets the immune system and weakens people's defence systems against infections and some types of cancer. As the virus destroys and impairs the function of immune cells, infected individuals gradually become immunodeficient. Immune function is typically measured by CD4 cell count.

Immunodeficiency results in increased susceptibility to a wide range of infections, cancers and other diseases that people with healthy immune systems can fight off. The most advanced stage of HIV infection is Acquired Immunodeficiency Syndrome (AIDS), which can take from 2 to 15 years to develop depending on the individual. AIDS is defined by the development of certain cancers, infections, or other severe clinical manifestations.

Signs and Symptoms
The symptoms of HIV vary depending on the stage of infection. Though people living with HIV tend to be most infectious in the first few months, many are unaware of their status until later stages. The first few weeks after initial infection, individuals may experience no symptoms or an influenza-like illness including fever, headache, rash, or sore throat.

As the infection progressively weakens the immune system, an individual can develop other signs and symptoms, such as swollen lymph nodes, weight loss, fever, diarrhoea and cough. Without treatment, they could also develop severe illnesses such as tuberculosis, cryptococcal meningitis, severe bacterial infections and cancers such as lymphomas and Kaposi's sarcoma, among others.

Transmission
HIV can be transmitted via the exchange of a variety of body fluids from infected individuals, such as blood, breast milk, semen and vaginal secretions. Individuals cannot become infected through ordinary day-to-day contact such as kissing, hugging, shaking hands, or sharing personal objects, food or water.

Risk factors

Behaviours and conditions that put individuals at greater risk of contracting HIV include:

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1. *Having unprotected anal or vaginal sex;*
2. *Having another sexually transmitted infection such as syphilis, herpes, chlamydia, gonorrhoea, and bacterial vaginosis;*
3. *Sharing contaminated needles, syringes and other injecting equipment and drug solutions when injecting drugs;*
4. *Receiving unsafe injections, blood transfusions, tissue transplantation, medical procedures that involve unsterile cutting or piercing; and*
5. *Experiencing accidental needle stick injuries, including among health workers*

Diagnosis

Serological tests, such as RDTs or enzyme immunoassays (EIAs), detect the presence or absence of antibodies to HIV-1/2 and/or HIV p24 antigen. No single HIV test can provide an HIV-positive diagnosis. It is important that these tests are used in combination and in a specific order that has been validated and is based on HIV prevalence of the population being tested. HIV infection can be detected with great accuracy, using WHO prequalified tests within a validated approach.

It is important to note that serological tests detect antibodies produced by an individual as part of their immune system to fight off foreign pathogens, rather than direct detection of HIV itself.

Most individuals develop antibodies to HIV within 28 days of infection and therefore antibodies may not be detectable early, during the so-called window period. This early period of infection represents the time of greatest infectivity; however, HIV transmission can occur during all stages of the infection.

It is best practice to also retest all people initially diagnosed as HIV-positive before they enrol in care and/or treatment to rule out any potential testing or reporting error. Notably, once a person diagnosed with HIV and has started treatment they should not be retested.

Testing and diagnosis of HIV-exposed infants has been a challenge. For infants and children less than 18 months of age, serological testing is not sufficient to identify HIV infection – virological testing must be provided (at 6 weeks of age, or as early as birth) to detect the presence of the virus in infants born to mothers living with HIV. However, new technologies are now becoming available to perform the test at the point of care and enable return of the result on the same day to accelerate appropriate linkage and treatment initiation.

HIV testing services
HIV testing should be voluntary and the right to decline testing should be recognized. Mandatory or coerced testing by a health care provider, authority, or by a partner or family member is not acceptable as it undermines good public health practice and infringes on human rights.

New technologies to help people test themselves are being introduced, with many countries implementing self-testing as an additional option to encourage HIV diagnosis. HIV self-testing is a process whereby a person who wants to know his or her HIV status collects a specimen, performs a test and interprets the test results in private or with someone they trust. HIV self-testing does not provide a definitive HIV-positive diagnosis – instead, it is an initial test which requires further testing by a health worker.

The sexual partners and drug injecting partners of people diagnosed with HIV infection have an increased probability of also being HIV-positive. WHO recommends assisted HIV partner notification services as a simple and effective way to reach these partners, many of whom are undiagnosed and unaware of their HIV exposure and may welcome support and an opportunity to test for HIV.

All HIV testing services must follow the 5 Cs principles recommended by WHO:

1. *Informed Consent*
2. *Confidentiality*
3. *Counselling*
4. *Correct test results*
5. *Connection (linkage to care, treatment and other services).*

Prevention
Individuals can reduce the risk of HIV infection by limiting exposure to risk factors. Key approaches for HIV prevention, which are often used in combination, are listed below.

Male and female condom use
Correct and consistent use of male and female condoms during vaginal or anal penetration can protect against the spread of sexually transmitted infections, including HIV. Evidence shows that male latex condoms have an 85% or greater protective effect against HIV and other sexually transmitted infections (STIs).

Testing and Counselling for HIV and STIs
Testing for HIV and other STIs is strongly advised for all people exposed to any of the risk factors. This way people learn of their own infection status and access necessary prevention and treatment services without delay. WHO also recommends offering testing for partners or couples. Additionally, WHO is recommending assisted partner notification approaches so that people with HIV receive support to inform their partners either on their own, or with the help of health care providers.

Testing and counselling, Linkages to Tuberculosis Care
Tuberculosis (TB) is the most common presenting illness and cause of death among people with HIV. It is fatal if undetected or untreated and is the leading cause of death among people with HIV, responsible for 1 of 3 HIV-associated deaths.

Early detection of TB and prompt linkage to TB treatment and ART can prevent these deaths. TB screening should be offered routinely at HIV care services and routine HIV testing should be offered to all patients with presumptive and diagnosed TB. Individuals who are diagnosed with HIV and active TB should urgently start effective TB treatment (including for multidrug resistant TB) and ART. TB preventive therapy should be offered to all people with HIV who do not have active TB.

Voluntary Medical Male Circumcision (VMMC)
Medical male circumcision reduces the risk of heterosexually acquired HIV infection in men by approximately 60%. This is a key prevention intervention supported in 15 countries in Eastern and Southern Africa (ESA) with high HIV prevalence and low male circumcision rates. VMMC is also regarded as a good approach to reach men and adolescent boys who do not often seek health care services. Since the 2007 WHO recommendation for VMMC as an additional prevention strategy, nearly 15 million adolescent boys and men in ESA were provided a package of services including HIV testing and education on safer sex and condom use.

Antiretroviral drug use for prevention

Prevention Benefits of ART
A 2011 trial has confirmed that if an HIV-positive person adheres to an effective ART regimen, the risk of transmitting the virus to their uninfected sexual partner can be reduced by 96%. The WHO recommendation to initiate ART in all people living with HIV will contribute significantly to reducing HIV transmission.

Pre-Exposure Prophylaxis (PrEP) for HIV-negative partner
Oral PrEP of HIV is the daily use of ARV drugs by HIV-negative people to block the acquisition of HIV. More than 10 randomized controlled studies have demonstrated the effectiveness of PrEP in reducing HIV transmission among a range of populations including serodiscordant heterosexual couples (where one partner is infected and the other is not), men who have sex with men, transgender women, high-risk heterosexual couples, and people who inject drugs.

WHO recommends PrEP as a prevention choice for people at substantial risk of HIV infection as part of a combination of prevention approaches. WHO has also expanded these recommendations to HIV-negative women who are pregnant or breastfeeding.

Post-Exposure Prophylaxis for HIV (PEP)
Post-exposure prophylaxis (PEP) is the use of ARV drugs within 72 hours of exposure to HIV in order to prevent infection. PEP includes counselling, first aid care, HIV

testing, and administration of a 28-day course of ARV drugs with follow-up care. WHO recommends PEP use for both occupational and non-occupational exposures and for adults and children.

Harm reduction for people who inject and use drugs

People who inject drugs can take precautions against becoming infected with HIV by using sterile injecting equipment, including needles and syringes, for each injection and not sharing drug using equipment and drug solutions. Treatment of dependence, and in particular opioid substitution therapy for people dependent on opioids, also helps reduce the risk of HIV transmission and supports adherence to HIV treatment. A comprehensive package of interventions for HIV prevention and treatment includes:

(a). Needle and syringe programmes;
(b). Opioid substitution therapy for people dependent on opioids and other evidence-based drug dependence treatment;
(c). HIV testing and counselling;
(d). HIV treatment and care;
(e). Risk-reduction information and education and provision of naloxone;
(f). access to condoms; and
(g). Management of STIs, tuberculosis and viral hepatitis.

Elimination of Mother-to-Child Transmission of HIV (EMTCT)

The transmission of HIV from an HIV-positive mother to her child during pregnancy, labour, delivery or breastfeeding is called vertical or mother-to-child transmission (MTCT). In the absence of any interventions during these stages, rates of HIV transmission from mother-to-child can be between 15–45%. MTCT can be nearly fully prevented if both the mother and the baby are provided with ARV drugs as early as possible in pregnancy and during the period of breastfeeding.

WHO recommends lifelong ART for all people living with HIV, regardless of their CD4 count clinical stage of disease, and this includes women who pregnant or breastfeeding. In 2016, 76% of the estimated 1.4 million pregnant women living with HIV globally received ARV treatments to prevent transmission to their children. A growing number of countries are achieving very low rates of MTCT and some (Armenia, Belarus, Cuba and Thailand) have been formally validated for elimination of MTCT of HIV as a public health problem. Several countries with a high burden of HIV infection are also progressing along the path to elimination.

Treatment

HIV can be suppressed by combination ART consisting of 3 or more ARV drugs. ART does not cure HIV infection but suppresses viral replication within a person's body and allows an individual's immune system to strengthen and regain the capacity to fight off infections.

2.1.1 Gender, AGYW and HIV

As has been noted before, HIV prevalence of HIV and AIDS is high among AGYW. It is important to understand the factors that pre-dispose this group. The materials below explain why AGYW experience special vulnerability when it comes to HIV and AIDS.

UNAIDS HIV Prevention among Adolescent Girls and Young Women: Putting HIV Prevention Among Adolescent Girls and Young Women on The Fast-Track and engaging Men and Boys. UNAIDS Guide (2016)

Why adolescent girls, women, adolescent boys and men?
The programmes described in this document aim to reduce HIV incidence among adolescent girls and young women. The epidemic dynamics, however, require programming that cuts across age and gender. New HIV infections among adolescent girls and young women are substantially higher than among males of the same age because HIV is more commonly acquired from male sexual partners who are a few or several years older. Gender inequality also disproportionately affects girls and women, but addressing it requires working with both women and men to consider not only unequal power dynamics, but also risk practices and underlying social and gender norms. Several trials of biomedical and other combination HIV prevention programmes that had an effect on biological outcomes have focused on both women and men. HIV prevention and sexual and reproductive health and rights (SRHR) programmes for adolescent boys and men should also be available, and guidance is under development. Guidance also is under development to make voluntary medical male circumcision (VMMC) a gateway to health for adolescent boys and young men.

Why rights, empowerment and gender equality?
The fact that adolescent girls and young women are substantially affected by the HIV epidemic is partially due to gender roles prevalent in society, to social norms that affect them, and to their limited access to education and resources, all of which prevent adolescent girls and young women from making essential decisions about their health and lives. Harmful laws and practices in relation to early marriage, early pregnancy and lack of access to confidential sexual and reproductive health services prevent adolescent girls and young women from obtaining essential HIV prevention information and services. Respect for adolescent autonomy and decision-making, providing empowerment, and changing gender norms and laws can enhance access to—and ability to use— HIV prevention services among adolescent girls and young women.

Which factors influence high HIV incidence among young women?
It is critical to understand which factors drive HIV acquisition and transmission by and to adolescent girls and young women. Many of these factors are interrelated with each other and with factors relevant to adult populations. This implies that the high HIV incidence of adolescent girls and young women cannot be explained simply by their own behaviour and biology, but that it must be interpreted in the entire epidemic

context. The causes of risk, which have been analysed elsewhere, can be grouped into behavioural, structural and biological factors (21, 23–27).

Behavioural factors

Behavioural factors related to HIV risk among adolescent girls and young women involve individual and relational factors; in other words, they are linked to the behaviour of both young women and their male partners. Behavioural factors are closely linked to social and gender norms on relationships, sexuality and marriage, as well as structural factors (such as population mobility and gender inequality).

Age-disparate sex

The age of sexual partners is a key factor that contributes to HIV incidence being substantially higher among adolescent girls and young women than among males of the same age. The majority of women are in age-disparate relations with men who are between one and 10 years older). In such relationships, not only is there a higher likelihood of older men being already infected, but also of unequal power dynamics within the relationship that may prevent safer sex.

Multiple partnerships

Having a greater number of sexual partners—or having a partner with a history of having multiple partners—is consistently associated with higher levels of HIV acquisition in eastern and southern Africa. Demographic Health Surveys (DHS) and recent national HIV incidence surveys confirm this association (19, 20, 29, 30). The risk of acquiring HIV applies to adolescent girls and young women with multiple partnerships, as well as to those with male partners who have (or have had) multiple partners. In that sense, any new non-regular or regular relationship may connect adolescent girls and young women to a wider sexual network.

Sex work and sexually exploited adolescent girls

HIV incidence among young sex workers and sexually exploited adolescent girls remains high in many settings in sub-Saharan Africa. It is particularly important that young sex workers and sexually exploited adolescent girls are reached early with programmes, since a significant proportion of new infections may occur soon after they begin to sell sex.

Transactional sex

Transactional sexual relationships are non-marital, non-commercial sexual relationships based on an assumption that sex will be exchanged for material support or other benefits. A review suggests that women who engaged in transactional sex were more likely to be HIV-positive, and that adolescent girls and young women engage in these relationships for three main groups of reasons: accessing basic needs, increasing their social status and receiving material expressions of love from male partners.

Early sexual debut

A systematic review found associations between early sexual debut and HIV explained by a combination of factors: early onset of sex itself, an effect on later engagement in risky sexual behaviours and biological factors. Even in contexts with relatively late age of debut (like Zimbabwe), major HIV epidemics among young women have been observed. In a multi-country study, over 30% of women who reported first sex before the age of 15 years described that sexual experience as being forced.

Gaps in knowledge and limited personalized risk perception

Although knowledge of basic prevention methods is relatively high in priority countries, there are still considerable gaps in comprehensive basic knowledge among adolescent girls, young women, and the population overall. Knowledge of specific risk factors (such as transmission in sexual networks or the risk of age-disparate sex and anal sex), of newer biomedical prevention methods (such as PrEP), or of links between HIV and gender-based violence, is likely to be lower. Although people understand that the population-level risk of HIV is high in eastern and southern Africa, there still are gaps in personalized risk perception. In one survey, a significant portion of young HIV-positive adults who did not yet know their HIV status did not perceive themselves to be at higher risk of HIV (35). Similarly, young women at high risk did not consistently use PrEP due to low risk perception, while high risk perception was shown to be associated with higher use of PrEP and more frequent use of condoms among adolescents (between two and five times more frequent.

Biological factors

As with behavioural factors, biological factors have an individual and a relational dimension. HIV acquisition among adolescent girls and young women is influenced both by their own biological susceptibility and by biological factors related to male partners. HIV incidence and per-act transmission rates among adolescent girls in southern Africa are exceptionally high, suggesting that biological factors (in combination with behavioural and structural patterns) enhance HIV acquisition in the region.

Biological susceptibility of women

The per-act transmission risk for women during vaginal sex has been found to be higher than for men in most (but not all) studies. The higher susceptibility of women can be explained by a number of factors: the ability of HIV to pass through the cells of the vaginal lining, the larger surface area of the vagina
compared to the penis, increased mucosal HIV exposure time, the potential for micro-abrasions and tears of the vagina or cervix, the higher concentration of HIV in semen than vaginal fluids, the increased expression of HIV co-receptors in cervical cells (compared to foreskin cells), and high levels of activation of the immune cells in the female genital tract.

Biological susceptibility of adolescent girls

In addition to factors explaining female susceptibility, adolescent girls may be at

increased risk because of other factors. In the immature cervix, a greater proportion of genital mucosa is very susceptible to HIV. Relatively high levels of genital inflammation and a vaginal microbiome perturbed by bacterial vaginosis also could enhance HIV acquisition (21).

High HIV viral load among male partners

Due to the lower uptake of antiretroviral therapy among men, it is likely that in most countries, fewer men than women are virally suppressed as suggested by studies in different settings. In addition, a review of data on viral load suggests that average levels of community viral load are particularly high in eastern and southern Africa, which may relate to coinfections and potentially to other factors, as well.

Low prevalence of male circumcision

This is associated with higher HIV prevalence in sub-Saharan Africa, and there is compelling evidence that VMMC reduces sexual HIV transmission from females to males. While there is no conclusive evidence that male circumcision reduces HIV transmission from men to women, models have shown that despite the increased risk of transmission during the healing period, young women would benefit indirectly from increased coverage of VMMC because of the reduced HIV prevalence among men.

Harmful practices

Susceptibility can be further exacerbated through harmful intravaginal practices like the use of substances to dry the vagina or intravaginal washing with soap. Sexual practices, like anal sex, which was reported to occur among adolescents in the context of limited HIV risk perception or virginity testing, may increase transmission.

Other infections

Presence of other Transmitted Infections and reproductive tract infections among adolescent girls and young women or their male partners is likely to increase HIV transmission.

Structural factors

The following contextual factors contribute causally to the above-mentioned direct factors, and they also may act as barriers to prevention uptake.

Harmful social and gender norms, gender inequality and unequal power dynamics
Societal gender norms around masculinity, femininity and the social acceptability of concurrent relations contribute to generating larger sexual networks. Cultural concepts of masculinity may encourage men to assume that wives, partners and daughters are the possessions of men, and most husbands expect or demand their so-called conjugal rights. Concepts of femininity expect subordination, which can imply over-sexualizing young women while also associating shame with female sexual expression. Presence of specific harmful cultural practices— such as virginity testing or sexual cleansing of widows—may place young widowed women at risk

of HIV. For young women, income inequality and lack of income (or lack of control over it) may contribute to transactional sex or early marriage. Unequal gender power dynamics in relationships are associated with not only gender-based violence, but also men's relative control over sexual decision-making, which can influence women's negotiation skills and space.

Low secondary school attendance
The limited access to secondary and tertiary education among adolescent girls and young women contributes to increased HIV incidence risk, while school attendance and educational attainment have been shown to be associated with lower HIV risk and reduced sexual risk behaviour.

Labour migration and spousal separation
Labour migration and urbanization contribute to rapid population movements, separation of couples and more frequent change of sexual partners. Studies have shown that migration is associated with higher HIV risk, which affects both the partner working away from home (in sub-Saharan Africa, this is more commonly men) and their sexual partners.

Barriers to accessing sexual and reproductive health and HIV services
Age of consent laws, stigma, service provider bias and discrimination limit the ability of young women to access health services, counselling and prevention tools (such as condoms, contraception, HIV testing and other services).

Orphanhood
Young women who are orphaned have been found to experience a higher risk of HIV infection and to engage in more risky sexual behaviour.

Child sexual abuse
Sexual abuse in childhood—often involving relatives, neighbours or teachers—can directly lead to HIV transmission and establish a cascade of developmental and psychological consequences resulting in a range of risk behaviours (such as earlier sexual debut, more sexual partners and substance use). These behaviours may increase a woman's risk of both acquiring HIV and of being subjected to violence in adulthood.

Gender-based violence
A systematic review and meta-analysis confirmed an association between HIV and intimate partner violence, including physical violence and the combination of physical and sexual intimate partner violence. The indirect pathways and common root causes may include gender norms, perceptions of masculinity and power relations.

Marriage patterns
As shown …, the demographic profile of high-prevalence countries in eastern and southern Africa varies. Countries in southern Africa (Botswana, Lesotho, Namibia, South Africa and Swaziland) are characterized by lower marriage rates than many

of the other priority countries in the region (where marriage rates are higher). Such demographic patterns are important to consider when attempting to reach young women and their male partners. While countries with low marriage rates will require a strong focus on transmission in casual relations, relationship formation and non-marital long-term relations, countries with early and higher marriage rates also may require more focus on prevention before marriage, in the early stages of marriage and in extramarital relations. Early marriage, particularly if it is with an older male partner, also may contribute to risk in some countries. Many of the behavioural and biological factors influencing HIV acquisition among adolescent girls and young women are relational, which emphasizes the need to design programmes in ways that also include men. There may be substantial differences in behavioural and structural factors between urban and rural areas, as well as regional differences within countries. The key factors identified at the country level will inform the prioritization of prevention strategies for young women in specific locations. Although HIV prevention in locations with high HIV prevalence is complex, declining numbers of new infections and HIV prevalence among young women in some countries (such as Botswana, Namibia, Zambia, Zimbabwe and several others) demonstrate that it is possible to halt and reverse HIV transmission, including among young women.

2.2. Gender Based Violence and HIV

Research shows that women who are exposed to violence have far higher chances of acquiring HIV than those not exposed to violence,[3] in addition to being less likely to access HIV and AIDS related services.

2.2.1. Defining "violence", "gender violence" and "sexual violence"

Gender Violence

The United Nations Declaration on Elimination of Violence Against Women (A/RES/48/104 of the 85th General Assembly plenary meeting, 20 December 1993) defines gender violence to mean any act of gender-based violence that results, or is likely to result, in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivations of liberty, whether occurring in public or private life. Such violence occur in various settings, including the family and community and may be perpetrated by both state and non-state actors. On this issue, the UNDP has rendered itself as excerpted below:

[3] See UN Women Understand the Linkages between HIV/AIDS and Violence against Women and Girls available at http://www.endvawnow.org/en/articles/677-understand-the-linkages-between-hiv-aids-and-violence-against-women-and-girls-.html (accessed on 23rd March 2018).

United Nations Development Programme (UNDP) Guidance Note: Gender-Based Violence in Crisis and Post-Crisis Settings
available at http://www.undp.org/content/dam/undp/library/gender/Gender%20and%20CPR/Guidance%20Note-%20Gender-based%20Violence%20in%20Crisis%20and%20Post-Crisis%20Settings.pdf

DEFINITION OF GENDER-BASED VIOLENCE

Gender-based violence is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females. Acts of GBV violate a number of universal human rights protected by international instruments and conventions. Many —but not all— forms of GBV are illegal and criminal acts in national laws and policies. Around the world, GBV has a greater impact on women and girls than on men and boys. The term "gender-based violence" is often used interchangeably, with the term "violence against women." The term "gender-based violence" highlights the gender dimension of these types of acts; in other words, the relationship between females' subordinate status in society and their increased vulnerability to violence. It is important to note, however, that men and boys may also be victims of gender-based violence, especially sexual violence. The nature and extent of specific types of GBV vary across cultures, countries, and regions. Examples include:

(a). Sexual violence, including sexual exploitation/ abuse and forced prostitution
(b). Domestic violence
(c). Trafficking
(d). Forced/early marriage
(e). Harmful traditional practices such as female genital mutilation, honour killings, widow inheritance, and others

Sexual Violence

Sexual violence is defined as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work."[4] This will include:

- *Acts of sexual violence includeingrape within marriage or dating relationships;*
- *Rape by strangers*
- *Unwanted sexual advances or sexual harassment, including demanding sex in return for favours*
- *Sexual abuse of mentally or physically disabled people*

[4] See WHO, World report on violence and health 2002 Edited by Etienne G. Krug, Linda L. Dahlberg, James A. Mercy, Anthony B. Zwi and Rafael Lozano available at http://www.who.int/violence_injury_prevention/violence/world_report/en/full_en.pdf.

- *Sexual abuse of children including adolescent girls*
- *Forced marriage or cohabitation, including the marriage of children;*
- *Denial of the right to use contraception or to adopt other measures to protect against sexually transmitted diseases*
- *Forced abortion*
- *Attempted rape*
- *Unwanted touching of intimate body parts*
- *Sexual harassment*
- *Forced prostitution*
- *Unwarranted insertion of objects in private parts*

2.2.2 Relationship between GBV and HIV and AIDS

According to the Global AIDS Alliance violence is a risk factor in HIV infection because:

- Violence against women is associated with an increased risk of acquiring sexually transmitted infections, which is a risk factor of HIV.
- Violent sexual assault can cause trauma to the vaginal wall making it more prone to infection
- Fear of violence prevents women from negotiating safe sex. For example, a study in South Africa found that women who have been forced to have sex are almost six times more likely to use condoms inconsistently than those who have not been coerced.
- Children who are sexually abused are more likely to engage in behaviors known to be risky for HIV as adults. They are also more likely to experience sexual or domestic violence.
- Boys who witness or experience family violence are more likely to commit rape.
- Men who are violent toward their intimate partners have been found to be more likely to have multiple sexual partners than men who are not violent toward their partners.
- Abused women are at greater risk of acquiring HIV.
- Women living with HIV have more lifetime experience of violence than HIV-negative women.
- As established by a WHO study, fear of violence was a barrier to HIV disclosure for an average of 25% of participating women. In some countries the proportion was as high as 86%.
- Fear of violence prevents women from seeking voluntary counseling and testing for HIV, returning for their test results, or getting treatment if they are HIV positive or services to prevent mother-to-child HIV transmission.

PART III

HIV AND AIDS, GBV AND THE RIGHT TO HEALTH AND THE LAW IN UGANDA

3.0. Introduction

The right to health, as sounded in international, regional and national law can be deployed in the protection of the rights of PLHIV. At the international level, the right to health is defined by the International Covenant on Economic, Social and Cultural Rights (ICESCR) and is further elaborated by General Comment No. 14 on the right to the highest attainable standard of health. At the African regional level, the right is protected by the African Charter on Human and Peoples Rights. The right to health is said to have four elements: (a) Availability; (b) Accessibility; (c) Acceptability; and (d) Quality all of which have been elaborated in General Comment No. 14. The right to health is wide enough to encompass the right to sexual and reproductive health, a key normative framework for dealing with HIV and AIDS.

3.1 Review of National and International Legislations

a) ICESCR

The ICESCR is the principal United Nations instrument that defines and protects economic, social and cultural rights. Adopted in 1966, the ICESCR requires states parties to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of their available resources, with a view to achieving progressively the full realisation of the rights recognized in the Covenant by all appropriate means.[5] This is the standard by which the performance of states with respect to the extent to which they have realized the substantive rights in the Covenant is to be measured. The UNCESCR, has issued interpretative guidelines of the provisions of the ICESCR in the form of what are described as "General Comments". The General Comments have canvassed several provisions of treaties and have been received by both judicial and non-judicial bodies as authoritative and highly persuasive legal interpretations of the provisions of the treaties. The General Comments have even informed legislative processes in some cases.

To give meaning to article 2(1), the UNESCR issued General Comment No 3: The nature of States parties' obligations.[6] This General Comment puts meaning to the obligations to "take steps", "progressive realisation", and "to the maximum of the available resources". The Committee has elaborated that to "take steps" requires states to take both legislative and non-legislative steps and is inclusive of ensuring

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[5] Article 2(1).

[6] (Fifth session, 1990), U.N. Doc. E/1991/23, annex III at 86 (1991), reprinted in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.6 at 14 (2003).

availability of judicial remedies. The Committee has emphasized that what is important is "appropriateness" of the means in every situation. Moreover, states are required to give the right protection within their national laws. This means that the rights, including the right to health, must be domesticated by incorporation in the Constitution as part of the justiciable rights – rights that can be enforced through judicial means.On "progressive realisation", the UNCESCR has said that the concept constitutes a recognition of the fact that full realization of all ESCRs will generally not be achievable in a short period of time. The Committee has warned though that the words "progressively", as seen under the Covenant should not be misinterpreted as depriving the obligation of all meaningful content. Rather, "progressive realization" should be seen as imposing an obligation to move as expeditiously and effectively as possible towards that goal.

Uganda is obliged, by virtue of its membership to the ICESCR, to ensure the protections therein are availed to the people at the domestic level. This can be done through the Constitution, legislation and judicial pronouncements. To what extent has Ugandan law incorporated these principles of international law particularly in the context of HIV and AIDS and GBV?

b) The HAPCA, 2014

The HAPCA, 2014 is the most comprehensive legislative response to HIV and AIDS in Uganda. This Act is important in two respects: first, it defines various obligations related to the prevention and control of HIV and AIDS, and second, it ascertains the rights of persons infected and affected by HIV and AIDS. This is in addition to prescribing offences and sanctions were the law has been breached.

Long Title to Act

AN ACT to provide for the prevention and control of HIV and AIDS, including protection, counselling, testing, care of persons living with and affected by HIV and AIDS, rights and obligations of persons living with and affected by HIV and AIDS; to establish the HIV and AIDS Trust Fund; and for related matters.

In line with the above title, the Act deals with several HIV and AIDS related matters. Prominent features of the Act include the following:

Features of HAPCA, 2014

- Obligation to take care not to infect oneself and other - section 2
- Obligations on health units which test to do pre and post counselling and to be done by professionals - sections 3 and 4.
- Non-disclosure of the identity of those tested
- Confidentiality of results - section 19
- Obligations of state with respect to control - Part IV, equitable access to services, universal treatment, prevent non-discrimination, take measures to prevent transmission,
- Establishment of HIV Trust Fund - section 25

- Prohibition of discrimination at work - section 32
- Discrimination in schools - 33
- Restrictions in travel - section 34
- Discrimination in access to credit - section 36
- Discrimination in health institutions - section 37
- Discrimination of children - section 38
- Offences - Part VIII

The Act is elaborated in other parts of this Handbook especially part VI on legal issues related to HIV and AIDS and GBV.

c) The Domestic Violence Act

The Domestic Violence Act, 2010 seeks to provide for the protection and relief for victims of domestic violence; to provide for the punishment of perpetrators of domestic violence; to provide for the procedure and guidelines to be followed by the court in relation to the protection and compensation of victims of domestic violence; to provide for the jurisdiction of court; to provide for the enforcement of orders made by the court; to empower the family and children's court to handle cases of domestic violence and for related matters.

In section 2, the Act defines "domestic violence" to constitute any act or omission of a perpetrator which— (a) harms, injures or endangers the health, safety, life, limb or well-being, whether mental or physical, of the victim or tends to do so and includes causing physical abuse, sexual abuse, emotional, verbal and psychological abuse and economic abuse; (b) harasses, harms, injures or endangers the victim with a view to coercing him or her or any other person related to him or her to meet any unlawful demand for any property or valuable security; (c) has the effect of threatening the victim or any person related to the victim by any conduct mentioned in paragraph (a) or (b); or (d) otherwise injures or causes harm, whether physical or mental, to the victim.

The Act deals with violence which happens in "domestic relationships". In section 3(1), "domestic relationship" is defined to mean "a family relationship, a relationship similar to a family relationship or a relationship in a domestic setting that exists or existed between a victim and a perpetrator". The provision gives the following scenarios that give rise to that relationship:

- *The victim is or has been married to the perpetrator;*
- *The perpetrator and the victim are family members related by consanguinity, affinity or kinship;*
- *The perpetrator and the victim share or shared the same residence;*
- *The victim is employed by the perpetrator as a domestic worker or house servant and the victim does or does not reside with the perpetrator;*

- *The victim is an employer of the perpetrator and does or does not reside with the perpetrator; or*

- *The victim is or was in a relationship determined by the court to be a domestic relationship.*

The Act makes domestic violence a crime and subjects a convicted perpetrator to a fine not exceeding forty-eight currency points or imprisonment not exceeding two years or to both.[7]

d) The Constitution of the Republic of Uganda

In general, the Uganda Constitution does not directly address matters to do with HIV and AIDS or even GBV. Indeed, the Constitution makes no direct mention to health as part of the obligations it imposes on the state. Nevertheless, various of its provisions may be read expansively to extend protections to PLHIV in the areas of health rights and GBV related violations. Article 45's declaration that: "The rights, duties, declarations and guarantees relating to the fundamental and other human rights and freedoms specifically mentioned in this Chapter shall not be regarded as excluding others not specifically mentioned", can reasonably be extrapolated to incorporate rights enshrined in the international instruments, especially those which Uganda has ratified. For this reason, one can argue that the right to health as derived from Article 12 of the ICESCR is part of the rights protected by the Constitution of Uganda.

3.2. The Constitution and the Right to Health

The right to health can be deduced from the Constitution's norms, including those set out in the Bill of rights and in the National Objectives and Directive Principles of State Policy ("National Objectives"). Objective XIV of the national objectives requires the state to endeavour to fulfil the fundamental rights of all Ugandans to social justice and economic development. The state is required, in particular, to ensure that all Ugandans enjoy rights and opportunities and access to education, health services, clean and safe water, work, decent shelter, adequate clothing, food security and pension and retirement benefits, all which are elements relevant in the attainment of health By virtue of Objective XX, the state is also required to take all practical measures to ensure the provision of basic medical services to the population. Even though the National Objectives are expressed as "guides" only, it is possible to use them to clarify the state's obligation or even shore up a claim in case a violation is alleged. Moreover, a recent amendment to the Constitution, vide Article 8A has somewhat bolstered the weight of the National Objectives hence made it more likely that a court would be persuaded that they have legal effect.

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[7] Section 4.

A purposive interpretation of some provisions of the Constitution can extend the reach of the bill of rights to cover the right to health. Under article 33(2), the state has a special obligation to protect women's rights in view of their "unique status and natural maternal functions in society." "Maternal functions" here connotes sexual and reproductive health rights of women. Under Article 34(3), no child shall be deprived of medical treatment by reason of religious or other beliefs. Article 39 in turn guarantees the right to a clean and healthy environment; an essential determinant of the right to health. Furthermore, the Constitution extends special protection to persons with disabilities and requires that their dignity be respected and that appropriate measures be taken to ensure that they realise their full mental and physical potential, all of which have implications on their right to health. Lastly, the Constitution in Article 24 provides that no person shall be subjected to any form of torture or cruel, inhuman or degrading treatment or punishment.

3.3. The Constitution and GBV

The Constitution does not directly address GBV and one has to rely on a tangential reading of its provisions to found a basis for dealing with GBV. The Article 24 prohibition against torture and degrading treatment and the article 21 guarantee on equality of the sexes are useful to the extent that GBV amounts to cruel treatment and is premised on gender discrimination respectively. Moreover, by dint of Article 33(2), laws, cultures, customs or traditions that are against the dignity, welfare or interest of women or undermine their status are prohibited. To the extent that some acts of violence may be justified on tradition and customs, then such would be unconstitutional. Practices that entail a violation of a woman's free will and the right to make choices related to sexuality (e.g. forced marriages) can be struck down on the basis of Article 31(1) and 33(3) which respectively guarantee the right to marry and found a family and emphasise freedom to consent to a marriage.

3.4. The Constitution and HIV and AIDS

Notwithstanding the absence of specific reference to HIV and AIDS within the Constitution, many of its clauses can be used creatively to extend its reach to cases of violations affecting PLHIV. Considering that infractions against PLHIV are generally in the nature of discriminatory conduct, the bar against discrimination and the requirement for equal treatment of all are particularly significant in this regard. (see Part V below).

PART IV

THE LEGAL ISSUES RELATED TO HIV AND AIDS AND GBV

4.0. Introduction

This part highlights the legal issues that arise in relation to HIV and AIDS and GBV and which could be the subject of litigation. The section also gives examples of cases and laws where these issues have been considered. Issues highlighted here include:

1. Discrimination
2. Privacy and confidentiality
3. Reproductive health and forced sterilization
4. Access to medicines

4.1. Discrimination

4.1.1. Defining discrimination

(Excerpt) **UNAIDS, HIV-Related Stigma, Discrimination and Human Rights Violations Case studies of successful programmes,**
UNAIDS Best Practice Collection (2015)

Understanding stigma and discrimination: forms and contexts

In order to identify potential solutions to HIV-related stigma and discrimination, it is necessary to understand what is meant by these concepts, to describe how they are manifested, and to analyse the relationships between them.

What is stigma?

Stigma has been described as a dynamic process of devaluation that 'significantly discredits' an individual in the eyes of others. The qualities to which stigma adheres can be quite arbitrary—for example, skin colour, manner of speaking, or sexual preference. Within particular cultures or settings, certain attributes are seized upon and defined by others as discreditable or unworthy. HIV-related stigma is multi-layered, tending to build upon and reinforce negative connotations through the association of HIV and AIDS with already-marginalized behaviours, such as sex work, drug use, and homosexual and transgender sexual practice. It also reinforces fears of outsiders and otherwise vulnerable groups, such as prisoners and migrants. Individuals living with HIV are often believed to deserve their HIV-positive status as a result of having done something 'wrong'. By attributing blame to particular individuals and groups that are "different", others can absolve themselves from acknowledging their own risk, confronting the problem and caring for those affected. Images of people living with HIV in the print and visual media may reinforce blame by using language that suggests that HIV is a 'woman's disease', a 'junkie's disease', an 'African disease', or a 'gay plague'. Religious ideas of sin can also help to sustain

and reinforce a perception that HIV infection is a punishment for deviant behaviour. Stigma is expressed in language. Since the beginning of the epidemic, the powerful metaphors associating HIV with death, guilt and punishment, crime, horror and 'otherness' have compounded and legitimated stigmatization. This kind of language derives from, and contributes to, another aspect underpinning blame and distancing: people's fear of life-threatening illness. Some fear-based stigma is attributable to people's fear of the outcomes of HIV infection—in particular, the high fatality rates (especially where treatment is not widely accessible), fear related to transmission, or fear stemming from witnessing the visible debilitation of advanced AIDS. Stigma is deeply rooted, operating within the values of everyday life. Although images associated with AIDS vary, they are patterned so as to ensure that AIDS-related stigma plays into, and reinforces, social inequalities. These inequalities particularly include those linked to gender, race and ethnicity, and sexuality. Thus, for example, men and women are often not dealt with in the same way when infected or believed to be infected by HIV: a woman is more likely to be blamed even when the source of her infection is her husband, and infected women may be less likely to be accepted by their communities.

What is discrimination?

When stigma is acted upon, the result is discrimination. Discrimination consists of actions or omissions that are derived from stigma and directed towards those individuals who are stigmatized. Discrimination, as defined by UNAIDS (2000) in the Protocol for Identification of Discrimination Against People Living with HIV, refers to any form of arbitrary distinction, exclusion, or restriction affecting a person, usually but not only by virtue of an inherent personal characteristic or perceived belonging to a particular group—in the case of HIV and AIDS, a person's confirmed or suspected HIV-positive status—irrespective of whether or not there is any justification for these measures. AIDS-related discrimination may occur at various levels. There is discrimination occurring in family and community settings, which has been described by some writers as 'enacted stigma'. This is what individuals do either deliberately or by omission so as to harm others and deny to them services or entitlements. Examples of this kind of discrimination against people living with HIV include: ostracization, such as the practice of forcing women to return to their kin upon being diagnosed HIV-positive, following the first signs of illness, or after their partners have died of AIDS; shunning and avoiding everyday contact; verbal harassment; physical violence; verbal discrediting and blaming; gossip; and denial of traditional funeral rites. Then there is discrimination occurring in institutional settings—in particular, in workplaces, health-care services, prisons, educational institutions and social-welfare settings. Such discrimination crystallizes enacted stigma in institutional policies and practices that discriminate against people living with HIV, or indeed in the lack of anti-discriminatory policies or procedures of redress. Examples of this kind of discrimination against people living with HIV include the following.

- Health-care services: reduced standard of care, denial of access to care and treatment, HIV testing without consent, breaches of confidentiality including

identifying someone as HIV-positive to relatives and outside agencies, negative attitudes and degrading practices by health-care workers.

- Workplace: denial of employment based on HIV-positive status, compulsory HIV testing, exclusion of HIV-positive individuals from pension schemes or medical benefits.

- Schools: denial of entry to HIV-affected children, or dismissal of teachers.

- Prisons: mandatory segregation of HIV-positive individuals, exclusion from collective activities.

At a national level, discrimination can reflect stigma that has been officially sanctioned or legitimized through existing laws and policies and enacted in practices and procedures. These may result in the further stigmatization of people living with HIV and, in turn, legitimate discrimination.

A significant number of countries, for example, have enacted legislation with a view to restricting the rights of HIV-affected individuals and groups. These actions include:

- The compulsory screening and testing of groups and individuals;

- The prohibition of people living with HIV from certain occupations and types of employment;

- Isolation, detention and compulsory medical examination, treatment of infected persons; and • limitations on international travel and migration
- including mandatory HIV testing for those seeking work permits and the deportation of HIV-positive foreigners.

Discrimination also occurs through omission, such as the absence of, or failure to implement, laws, policies and procedures that offer redress and safeguard the rights of people living with HIV.

4.1.2. HIV and AIDS discrimination and the law in Uganda

The general non-discrimination clause in Article 21 of the Constitution, as read together specific legislative standards as set out in the HAPCA, provide a formidable tool for challenging discriminatory conduct targeted at PLHIV. Under section 1 of the Act, discrimination is defined to mean

> *[A]n act of alienation, refusal, isolation, maltreatment, disgrace, prejudice or restriction of rights towards another person because of the awareness or suspicion that such person is living with HIV and AIDS or has a close relationship with a person living with HIV ... or suspected HIV-living person.*

In addition to the above, the Act requires the state to ensure the right of access to equitable distribution of health facilities, goods and services, including essential medicines on a non-discriminatory basis. Section 24 also obliges the state to ensure the right of equitable access to treatment, medical goods and services on a non-discriminatory basis. Specific laws outlaw discrimination in various aspects of life that have implications for PLHIV as the following discussion demonstrates.

(a) Discrimination in the workplace.

Section 32 of the Employment Act provides that a person shall not be denied access to any employment for which he or she is qualified, or transferred, denied promotion or have his or her employment terminated on the ground of his or her actual, perceived or suspected HIV status. In section 32(2), it is indicated that the prohibition shall not apply where an employer can prove that the requirements of the employment in question are not met, or that a person is in a particular state of health or medical or clinical condition that renders him or her incapable of performing his or her work. This provision was crafted to deal with the negative effects of stereotyping and stigmatization as far as access to employment and working condition is concerned.

Most stereotypes in this regard are based on misinformation about the medical effect of HIV and AIDS on one's capacity to work, as well as scientifically unfounded fears of transmission. In this regard, the South African case of *Hoffman v South African Airways* is illustrative.[8] In this case, in response to an advertisement, Mr. Hoffman applied for a job as cabin steward on South African Airways (SAA). Having passed all interviews, he was not offered the job because an HIV test done on him turned out positive. SAA argued it could not employ him because of his medical condition as he would not be fit for the job and that he posed a risk of transmitting the virus to passengers should there be an emergency. There was no medical evidence to support these assertions. SAA also argued that passengers would shun the Airline should they know that it had employed an HIV positive cabin attendant. It also argued that the life expectancy of HIV positive persons was short, and it would not make sense to spend resources on their training. Hoffman sued for discrimination on the ground of his HIV status. Medical evidence was adduced to prove that despite his HIV positive status, he was capable of work.

It was held that at the heart of the prohibition of unfair discrimination is the recognition that under the Constitution, all human beings, regardless of their position in society, must be accorded equal dignity. That dignity is impaired when a person is unfairly discriminated against. In the Court's opinion, the determining factor regarding the unfairness of the discrimination was its impact on the person discriminated against. The Court outlined the relevant considerations in this regard to include: (a) the position of the victim of the discrimination in society, (b) the purpose sought to be achieved by the discrimination, (c) the extent to which the rights or interests of the victim of the discrimination have been affected, and (d) whether the discrimination

[8] 2001 SA (1) [Constitutional Court).

has impaired the human dignity of the victim. While referring to the position of the victim, the Court held that:

> *People who are living with HIV constitute a minority. Society has responded to their plight with intense prejudice. They have been subjected to systemic disadvantage and discrimination. They have been stigmatised and marginalised. As the present case demonstrates, they have been denied employment because of their HIV positive status without regard to their ability to perform the duties of the position from which they have been excluded. Society's response to them has forced many of them not to reveal their HIV status for fear of prejudice. This in turn has deprived them of the help they would otherwise have received. People who are living with HIV/AIDS are one of the most vulnerable groups in our society. Notwithstanding the availability of compelling medical evidence as to how this disease is transmitted, the prejudices and stereotypes against HIV positive people still persist. In view of the prevailing prejudice against HIV positive people, any discrimination against them can, to my mind, be interpreted as a fresh instance of stigmatisation and I consider this to be an assault on their dignity. The impact of discrimination on HIV positive people is devastating. It is even more so when it occurs in the context of employment. It denies them the right to earn a living. For this reason, they enjoy special protection in our law.*[9]

The Court held further that the fact that some people who are living with HIV may, under certain circumstances, be unsuitable for employment as cabin attendants does not justify the exclusion from employment as cabin attendants of all people who are living with HIV.[10] Based on the principles and evidence above, the Court found in favour of Hoffman and directed SAA to employ him. SAA complied.

Similarly illustrative is the Nigerian case of *Georgina Ahamefule v. Imperial Medical Centre & Dr. Alex Molokwu* [11] In this case, Ms. Ahamefule was dismissed from her job on account of her HIV status. She had been subjected to diagnostic tests by her employer without information as to the nature of the tests, their outcome, and without any pre and after-test counselling. When her test came out positive, her employment was terminated. The question before court was, inter alia, whether conducting an HIV test on the Applicant without obtaining informed consent and providing pre- and post-testing counselling constituted battery and professional negligence. Also, the court had to determine whether terminating the Applicant's employment based on her HIV-positive status violated her right to non-discrimination under Articles 2, 18(3) and 28 of the African Charter on Human and Peoples' Rights.The Court took the view that a determination of the legality of the termination was to be done on the basis of common law, under which an employer could bring a contract of employment to an

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[9] Para 28.

[10] Para 32.

[11] 2012 Suit No. ID/1627/2000 Nigeria, High Court.

end with or without giving a reason but that where a reason was given, then it must be shown to have been justified. The reason given by the employer, i.e., that the employee posed a risk to other patients and staff was found to be unjustified in view of the fact that the Applicant's responsibility as an auxiliary nurse was to run errands for the health care providers. She neither provided medical services nor handled blood or sharp objects and therefore created no risk as alleged by the employer.

The significance of this decision is in its demonstration of the utility of the common law in determining issues relating to HIV based employment discrimination. For Uganda however, expansive statutory protection obviates the need to have to rely on common law.

(b) Discrimination in education

Section 33 of the HAPCA, 2014 provides that an educational institution shall not deny admission or expel, punish, segregate, deny participation in any event or activity, or deny any benefits or services to a person on the grounds only of the person's actual, perceived or suspected HIV status. Education is a right the access to which enables humans to actualise themselves. Its denial has serious implications on the future welfare of not just the victim, but the society at large. For this reason, the law bans acts or decisions whose effect is to compromise the right of PLHIV to access and enjoy educational opportunities.

(c) Discrimination in travel and habitation

In section 34, the HAPCA, 2014 deals with discrimination constituting restriction on travel and habitation. Section 34(1) provides that a person's freedom of abode, lodging, or travel, within or outside Uganda, shall not be denied or restricted on the grounds only of the person's actual, perceived, or suspected HIV status. Also, section 34(2) states that a person shall not be quarantined, placed in isolation, refused lawful entry, or deported from Uganda on the grounds only of the person's actual, perceived or suspected HIV status. Transport providers may not refuse to board a passenger on account of their real or perceived sero-status. They may not likewise confine passengers in particular compartments or areas of the transport vessel. Owners of premises are also prohibited from refusing to rent, terminating tenancy, or otherwise interfering with possession or occupation of space on account of a person's HIV status.

(d) Discrimination in public service

Section 35 of the Act deals with the subject of discrimination in the public service, especially as far as holding political office is concerned. It is provided that a person shall not be denied the right to seek an elective or other public office on the ground only of the person's actual, perceived or suspected HIV status. This provision could be violated were for instance authorities refuse to nominate a person to run for political office based on the person's HIV status.

(e) Discrimination in access to credit and insurance

The subject of exclusion from credit and insurance services is addressed by section 36, which provides that a person shall not be compelled to undergo an HIV test or to disclose his or her HIV status for the purpose of gaining access to any credit or loan services, medical, accident or life insurance or the extension or continuation of any such services. The law however, under section 36(2), creates an exception with respect to health and life insurance cover in the sense that an insurer is only bound to not require a test where the cover is beneath a certain limit (the no-test limit). A person requiring cover beyond the limit may, if the insurer so stipulates, be required to undergo a test to which s/he must consent either way. Except to that limited degree, neither an insurance company, nor a financial institution require a mandatory test to qualify anyone for their services.

(f) Discrimination in healthcare

In terms of section 37, a person shall not be denied access to healthcare services in any health institutions or be charged a higher fee for any such services, on the ground only of the person's actual, perceived or suspected HIV status. The provision is complemented by section 39 which states that a health institution, whether public or private, and a health management organization, or medical insurance provider shall facilitate access to healthcare services to persons with HIV without discrimination on the basis of HIV status. These provisions can be used to ensure that persons living with HIV get medical services as a matter of medical necessity. This is an obligation that binds both private and public facilities. It does not imply that that the services to be provided should be free of charge. But if they are free, then every person including those who live with HIV should enjoy them on the same terms as everyone else.

(g) Nature of action to enforce provisions on discrimination

Section 40 of the Act defines liability in the form of a civil action. This means that any person who claims discrimination in the manner prohibited under the Act has the right to file a civil suit and obtain remedies such as damages.

4.2. Privacy and Confidentiality

Privacy and confidentiality are not only important from a human rights perspective but also from a public health angle. As a human right, the right to privacy guarantees human dignity to the extent that it respects individual autonomy in the sense that individuals may hold information in secrecy. Lack of privacy takes away respect for a person and could degrade people to the point of interfering with their comfort. From the HIV and AIDS perspective, disclosure of HIV and AIDS status could, because of stigma and discrimination, prevent people from approaching medical facilities for fear of their status being revealed. This means that those living with the virus may not seek treatment, which increases the risk of their spreading it. Consent to treatment and medical procedures is also important to the extent that it guarantees security of the person and bodily integrity.

4.2.1. Privacy and the public health angle

Safeguarding privacy and confidentiality is important for both individuals and for society. Individuals are less likely to participate in health research or other socially and individually beneficial activities, including candid and complete disclosures of sensitive information to their physicians, if they do not believe their privacy is being protected. When stigma keeps people from communicating sensitive health information, prevention, care, support, and treatment becomes difficult. Confidentiality of medical information is especially important for the most at-risk populations for HIV, such as injecting drug users, commercial sex workers, and men who have sex with men. Especially for such populations, stigma, discrimination, and criminalization can limit access to care, inhibit service uptake, and reduce patient disclosure of risks.

4.2.2. The law on privacy and confidentiality and implications for HIV and AIDS

The HIV Prevention and Control Act deals with the subject of privacy and confidentiality in a comprehensive manner and particularly in the context of testing and disclosure of results. Section 8(2) requires medical units that conduct testing to maintain a record of the identity of a person tested but prohibits them from disclosing the same except in accordance with the law and medical standards of disclosing or releasing personal medical information. Indeed, contravention of this provision is an offence under section 8(4).

Section 9 requires informed consent of the person being tested. Where a person is incapable of consenting due to unconsciousness, unsoundness of mind, being minors or suffering from any impairment rendering him or her incapable of giving consent, such consent, may undersection 10(1) be given by either a guardian, next of kin, caretaker or agent. In terms of section 11 though, consent may be dispensed with where it is either unreasonably withheld, or in an emergency due to grave medical or psychiatric condition and the medical practitioner or other qualified officer reasonably believes that such a test is clinically necessary or desirable in the interest of the person. Consent may also be dispensed with under section 14 if directed by court. In addition, consent is dispensed with under section 12 in respect of a person who is apprehended for a sexual offence.

Section 18(1) stresses that the results of an HIV test shall be confidential and shall only be disclosed or released by a medical practitioner or other qualified officer to the person tested. The exception is if the disclosure is to any of the following persons: (a) a parent or guardian of a minor; (b) a parent or guardian of a person of unsound mind; (c) a legal administrator or guardian, with the written consent of the person tested; (d) a medical practitioner or other qualified officer who is directly involved in the treatment or counselling of that person, where the HIV status is clinically relevant; (e) any other person with whom an HIV infected person is in close or continuous contact including a sexual partner, if the nature of the contact, in the opinion of the medical practitioner or other qualified officer, poses a clear and present danger of

HIV transmission to that person; (f) a person authorized by the Act or any other law; (g) any other person as may be authorized by a court; or (h) any person exposed to blood or bodily fluid of a person tested. Obligations of confidentiality are also imposed on those in possession of information relating to the HIV status of any person.[12]

There are no provisions in the Act that deal with the subject of consent to treatment. Nonetheless, consent to treatment is a matter of the common law and the right to privacy. Except in circumstances where the person is unable to give consent, consent must be given before a person is subjected to any form of treatment. .

4.3. Reproductive Health Rights and Forced Sterilisation

One of the issues which affects persons living with HIV has to do with enjoyment of their reproductive health rights. Most affected are women. Sometimes, women become victims of perceptions that persons living with HIV should not have children or enjoy other reproductive rights. Medical advancement has now made it possible for HIV positive mothers to deliver non-positive babies. Women living with HIV encounter challenges relating to their sexual and reproductive health and rights including their rights to exercise control over their sexuality, a right recognised as a component of the right to the highest attainable standard of health.[13] It has been demonstrated that in many African countries, women living with HIV are either compelled to undergo HIV testing or subjected to forced sterilisation.[14] This state of affairs is illustrated in the Namibian case of *Government of Namibia v. LM and others.*[15] In this case, three patients of various public hospitals claimed that they had been sterilised without their informed consent, which they argued was done because of their HIV status. The Supreme Court held that informed consent related to the rights recognised in the Namibian Constitution, including the rights to dignity, to physical integrity and to found a family. The Court noted that it was the woman's choice to decide to bear children or not, and that the decision must be made freely and voluntarily. In the opinion of the Court, the evidence on record suggested no proof of informed consent being given because the respondents did not have the intellectual and emotional capacity to give informed consent.

4.4. Access to Medicines

Over the years, medical science has changed the narrative that being HIV positive was a death sentence. There now exists antiretroviral therapies whose effect is reduce viral loads to such level that they no longer are capable of morphing into

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[12] Section 19(1).

[13] Centre for Human Rights, University of Pretoria, Center for Reproductive Health Rights and Faculty of Law, University of Toronto Legal Grounds: Reproductive and Sexual Rights in Sub-Saharan African Courts, Volume III (2017) Pretoria University a Law Press, at p 186.

[14] As above.

[15] Case No. SA 49/2012, NASC 19 Namibia, Supreme Court.

HIV thus enabling patients to live productive lives. The critical issue has been the degree of access to these medicines in view of their cost. For this reason, it has become part of the obligation of the state, in the context of the right to health, to invest resources that will ensure that these medicines, now deemed essential, are available to their populations either freely or cost effectively, equitably and without discrimination.

The African Commission on Human and People's Rights passed the Resolution on Access to Health and Needed Medicines in Africa on 24th November 2008 to clarify state obligations on essential medicines.[16] In this Resolution, the Commission urges state parties undertake several measures that will guarantee access to needed medicines. These include: ensuring availability in sufficient quantities of needed medicines, including existing medicines and the development of new medicines needed for the highest attainable level of health; accessibility of needed medicines to everyone without discrimination, acceptability of medicine supplies, being respectful of cultural norms and medical ethics, and available medicines are safe, effective and medically appropriate. States are also urged to promote access to medicines by refraining from measures that negatively affect access, protect access to needed medicines from actions by third parties through regulatory systems that, and fulfil access to medicines by adopting all necessary and appropriate positive measures to the maximum of its available resources to promote, provide and facilitate access to needed medicines.

Currently, there exists comparative jurisprudence that can guide in the delineation of the responsibility of the state in the context of provision of essential HIV medicine. The Kenyan case of *Patricia Asero and Others v Attorney General* provides some useful pointers.[17] Here, the petitioners challenged certain provisions of the Anti-Counterfeit Act, 2008, whose effect was to render generic HIV medicines counterfeits, prohibit their importation and hence impair their access thereto considering that their treatment regime consisted mainly of cocktails made of generic medicines. The Court agreed with their argument and held that the definition of 'counterfeit' in section 2 of the Act was likely to be read as including generic medication, thereby criminalising importation of essential generics which were not in themselves illegal. [18]

In South Africa, the Constitutional Court dealt with the subject of access to medicines that would prevent transmission of HIV from mother to child during child birth in the case of Minister of Health and Others v Treatment Action Campaign and Others (No 2).[19] The case challenged a government programme that while permitting the distribution of Nevirapine, a drug that reduced the risk of a HIV positive mother

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[16] Adopted at the 44th Ordinary Session of the Commission held in Abuja, Federal Republic of Nigeria, from the 10th to 24th November 2008.

[17] Petition No. 409 of 2009 [High Court of Kenya].

[18] Para 78.

[19] (CCT8/02) [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002).

passing on the virus to her child, restricted it to a few medical facilities. Even though the government argued that the drug was still under test, its efficacy not having been proven, evidence existed that suggested that the drug had been in use without any safety concerns militating against its administration, and that in fact, the government had registered it. It was held that restrictions such as had been put to limit the availability of Nevirapine to a few select test sites were unreasonable under the circumstances and that the government ought to make the drug available at all public hospitals and other areas that were not necessarily research or training sites.[20.]

4.5. Remedies for Survivors of Domestic Violence

The Domestic Violence Act is special to the extent that it makes provision for various remedies for victims of domestic violence and in this regard defines mandates and obligations of various structures. The mechanisms that could be utilised for relief include local councils courts, the Police and magistrates' courts.

i) Local Council Court

The Act allows victims of domestic violence to lodge complaints before the local council court where the victim resides.[21] The procedure the courts should follow once a complaint is received is described in detail.[22] The local council courts upon finding a violation of the Act are empowered to give the following orders.

(a) Caution;
(b) Apology to the victim;
(c) Counselling;
(d) Community service;
(e) A fine not exceeding twenty-five currency points;
(f) Compensation;
(g) Reconciliation;
(h) Declaration;
(i) Restitution;
(j) Attachment and sale

There are detailed procedures with respect to when the courts make referrals to the police or magistrate's court,[23] handling cases in which children are involved,[24] and reporting cases of domestic violence to probation and social welfare officers.[25]

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[20] Para 93.
[21] Section 6(1).
[22] Section 6(2) and (3).
[23] Section 6(6).
[24] Section 6(7) and (8).
[25] Section 6(9).

ii) The Police

The Act imposes the following obligations on police officers who either receive or investigate cases of domestic violence:

(a) Assist the victim, including giving assistance or advice in obtaining shelter;
(b) Where signs of physical or sexual abuse are evident, ensure that the victim undergoes a medical examination and receives medical treatment;
(c) Advise the victim of the right to apply for relief under this Act and the right to lodge a criminal complaint; and
(d) Offer procedural guidance and any assistance as may be necessary to ensure the well-being of the victim, the victim's representative and other witnesses.

iii) Magistrates Courts

Under the Act, Magistrates courts have powers to try offences of domestic violence.[26] In addition to imposing fines or custodial penalties on offenders, magistrates' courts have the power to order the payment of compensation to the victim by the offender.[27] Guidelines for detrmining this compensation are laid out in the Second Schedule to the Act. The magistrate courts also have powers to issue "protection orders" by which a perpetrator is ordered to keep away from the victim or desist from conduct that injures or threatens the victim.[28] This is upon application by the victim or their representative. A format for the application for a protection order is provided in schedule 3 of the Act.

4.6. Dealing with GBV through legislation on sexual offences

The Penal Code Act commits Chapter XIV thereof to "Offences Against Morality", under which are various sexual offences.[29] These include rape,[30] defilement,[31] indecent assault,[32] and detention with sexual intent among others.[33] The state, through the police and the Department of Public Prosecutions (DPP), has an obligation to prosecute offenders in relation to the above offences and to ensure that perpetrators are held accountable and kept away from society to protect women and other persons. For this reason, it is important that conduct constituting any of the above offences is reported to the police, promptly investigated and prosecuted.

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[26] Section 9(1).
[27] Section 4(2).
[28] See section 10.
[29] Penal Code Act, Laws of Uganda, Chapter 120.
[30] Section 123.
[31] Section 129.
[32] Section 128.
[33] Section 134.

4.6.1. Obtaining evidence in sexual offences

The nature of evidence required to successfully prosecute a sexual offence in court necessitates that a victim reports an incident as soon as it occurs. In rape and defilement cases, for instance, medical evidence is important for purposes of proving sexual activity and,, in the case of rape, lack of consent. A key concern should be preservation of evidence which byy its nature would likely disappear, or be destroyed by washing off, or passage of time. It is critical that such evidence is collected immediately. Care must also be taken that a victim is not subjected to additional trauma in the course of collecting evidence.

4.6.2. Private prosecution

There could be cases where the police or the DPP shows no interest to prosecute a matter. One remedy here is to undertake private prosecution, which is a procedure under section 42 of the Magistrates Court Act.[34] Section 42(3) thereof provides that any person, other than a public prosecutor or a police officer, who has reasonable and probable cause to believe that an offence has been committed by any person may make a complaint of the alleged offence to a magistrate who has jurisdiction to try or inquire into the alleged offence, or within the local limits of whose jurisdiction the accused person is alleged to reside or be.

4.6.3. State Briefs

A practice has evolved in common law jurisdictions, including Uganda, by which private lawyers can assist state attorneys and prosecutors in prosecuting criminal cases. This comes in handy were the prosecutors lack the necessary expertise and professional time to effectively prosecute cases. The practice of state brief allows a private lawyer to sit with the prosecutor in court and while he or she may not address court, can support the prosecutor as they present evidence. State briefs can also be used to protect and argue for the rights of victims. Thus, state briefs can be used in criminal cases involving GBV to ensure effective prosecution and attention to the rights and needs of victims.

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[34] Magistrate Courts Act, Chapter 16, Laws of Uganda.

PART V

CASE SELECTION AND PREPARATION

5.0 Introduction

This part provides guidance on factors to consider in choosing a case to litigate, as well as preparing for the case. Sometimes, emotional or spontaneous selection of cases can result in bad litigation, or cases which neither add value nor address real issues. Moreover, even a good case, poorly prepared and prosecuted can result in a loss. Critically though, a poorly conceptualised case may result in bad precedent that may be difficult to undo. It is therefore important for litigators to have the skills that will enable them to not only select the right cases, but also prepare and pursue the same. Issues of choice of forum must also be contemplated.

5.1 Determining what to Litigate

Determining the case to take to court is a structured process guided by several considerations. Deliberate effort and time must be invested in the task.. A key determinant may be the nature of the work the litigating entity is involved in and the objective sought to be achieved. For instance, an organisation may have as one of its objectives the promotion of access to health care services for those living with HIV, while another may be interested in work around protection services. Equally so, another organisation may be committed to legal aid service provision for those living with HIV. It is critical that each of these decides to deal with a case within its area of expertise so as to deploy resources in an optimum way and also avoid duplication of efforts.

5.1.1. The Role of Research

The decision on what to litigate must be preceded by research, whether it takes the form of a rapid assessment, even long-term structured research, observations over a long period and so on. Triangulating the problem will influence the decision whether litigation is the most appropriate, or even the sole, solution to the problem presented. (see extract)

FACTOR 5 – RESEARCH

270. A critical, and often neglected facet of successful public interest litigation is the need for detailed research in advance of and during the litigation. We conclude that two different types of such research are needed: legal research and factual research.

271. The legal research is essential if public interest litigation is to be given a proper theoretical foundation. It involves a particular emphasis on making use of foreign law and international law which is often not easily accessible, but which can play a pivotal role.

272. The need for access to proper factual research is just as acute. Particularly in cases on socio-economic rights, many of the factual issues will be highly specialised and complicated, involving statistical, medical, social science or other information. Those involved in running such litigation must have access to such research capabilities – either within their own organisation or via alliances with other organisations.

Gilbert Marcus and Steven Budlender: ***A Strategic Evaluation of Public Interest in South Africa*** (2008) The Atlantic Philanthropies

Investigation of a potential case on HIV and AIDS and GBV may be informed by the following considerations:

(i) What is the HIV and AIDS and GBV related matter(s)?
(ii) Does the matter/events/law constitute a violation/abuse of a human or legal right?
(iii) Who are the persons affected or likely to be affected by the abuse or violation?
(iv) Who is responsible for the violation / abuse?
(v) Is litigation capable of addressing the violation/abuse?
(vi) What is the likely impact of such litigation?
(vii) Has the matter been the subject of litigation, either in or outside Uganda and what can be learnt?

5.1.2. Choosing a Litigation Strategy - Lessons from The Treatment Action Campaign (TAC)

Once an issue has been selected for litigation, a clear litigation strategy must be developed. Litigation cannot be effective unless combined with other advocacy strategies. These could include public campaigns, advocacy for legislative reform, and research and training. In HIV & AIDS rights advocacy, some lessons can be learnt from the strategies adopted by the Treatment Action Campaign (TAC) in South Africa.

The Experiences of Treatment Action Campaign (TAC) Excerpt from article by Mark Heywood and Section 27, South Africa
"The Treatment Action Campaign's Quest for Equality in HIV and Health: Learning from and Lessons for the Trade Union Movement" Global Labour Journal, 2015, 6(3), Page 314

Continuity and Innovation: Old and New Strategies for Building People's Power
The TAC was started by a small group of political activists. Within the founding group only Zackie Achmat was living with HIV, and a minority were women and black. But our aim was to build a mass movement of poor and working-class people, dominated and led by people living openly with HIV and by women. However, then as now,

HIV was heavily stigmatised. In 1998 less than ten people out of the estimated two million people infected were open about having HIV.

To try to overcome these challenges, the TAC combined both the old and proven methods of the struggle, learned particularly from the United Democratic Front (UDF) and COSATU, with novel and pioneering strategies, some of them imported from the struggle for AIDS treatment in the United States. The old methods included popular education and mobilisation. The new method was to combine this with human rights advocacy and, where necessary, with social justice litigation, now made possible by South Africa's progressive pro-poor Constitution. The TAC's formula for building people's power might be described as follows:

Social Mobilisation through making Political Issues Moral Ones
+
Launching Campaigns that Captured Public Imagination and Conviction
+
Empowering Communities through Treatment Literacy
+
Use of Law
+
Effective Use of Media in the TAC's campaigns, all the parts of this formula were usually implemented in combination.

Poor law: invoking the South African Constitution

Under colonialism and apartheid, the law had been used to suppress all forms of political opposition as well as to disenfranchise black people and steal their land. In his unfinished autobiography, Joe Slovo, a barrister and later a leader of the SACP and ANC, said:

> *Until the Verwoerds and the Vorsters could no longer tolerate this, the individual trial could still be a battleground on whose terrain small and temporary social victories could be won. But at the end of the day the judicial system played as vital a role in maintaining South Africa's racist equilibrium as any other branch of the state administration (Slovo, 1995: 58). As a result, the ANC largely eschewed the legal system as a means of effecting change. However, in the dying years of apartheid the liberation movement, including the trade unions, found ways to use the law in the interests of the working class and poor, defending and opening up spaces for organisation and for mobilising communities (Thompson, 1988: 335–49).*

In democratic countries where there are labour laws and rights to organise, trade unions generally use the courts as a shield, often resorting to the labour courts to challenge unfair dismissals or in the event of industrial disputes or strikes. In contrast, the TAC used the law as a spear, as a way to frame, articulate and publicise its demands.

The TAC has led the way for a new approach to campaigning for social justice which regards the South African Constitution as a game-changer for the poor. This approach has made extensive use of the Bill of Rights in the South African Constitution, the law, the courts and human rights advocacy to build its power. The TAC is aided by the fact that the Constitution is South Africa's supreme law and creates a legal framework that is centred on the state's duties to respect, protect, promote and fulfil human rights (Heywood, 2013a, 2013b, 2015). This includes the right of 'everyone to have access to health care services' and the government's duty to 'progressively realise this right' by taking 'reasonable legislative and other measures within its available resources' (section 27 of the Constitution).

The TAC discovered that couching its demands for treatment as human rights and then locating them in the Constitution added to both its power and the legitimacy of its claims. Claims seem stronger and more just to the poor and marginalised (even more capable of realisation) when they are described as rights. Claims that are said to be legally entrenched rights are more difficult to dismiss by the rich and powerful especially when legal argument, lawyers and a social movement demand them.

An important point to stress (as this is often an argument made against the use of law) is that the TAC did not disempower its members through use of law or surrender its campaigns to lawyers and legal process. It worked closely with the AIDS Law Project, a specialist legal NGO, and demonstrated that mobilisation and legal action can interrelate and catalyse each other. A political campaign can give rise to a court case; a court case and the unfolding of different stages of the legal process can sustain a series of demonstrations and a rising movement. The TAC became the first post-apartheid social movement to take full advantage of the democratic legal framework and particularly of the Constitution, and went further than contemporary social movements in combining litigation with social mobilisation, and making legal advocacy and the use of the law courts into an art. Thus, between 2000 and 2007, the TAC drove its demands hand in hand with a series of court battles:

- in 2001 against the forty multinational pharmaceutical companies who had taken the South African government to court over its Medicines Act;

- in 2001 and 2002 against the South African government in what became a famous Constitutional Court case to demand a programme to prevent mother-to-child HIV transmission;

- in 2002–2003 against the pharmaceutical companies GlaxoSmithKline and BoehringerIngelheim, where the TAC instituted a complaint to South Africa's Competition Commission alleging that these companies were abusing their patents and market dominance to set excessive prices for essential ARVs;

- in 2004 against the South African government (again) to demand access to its plan for the roll-out of ARVs;

- in 2006 to demand that the right of access to ARV treatment be extended to prisoners. Although this case was about prisoner's rights, it was also the case that eventually ended the period of AIDS denialism. As a result of the embarrassment this caused at an international AIDS conference, after one of the prisoners died, the government asked for negotiations with the TAC that led to the country's first holistic and ambitious National Strategic Plan (NSP) on HIV covering the years 2007–2011.

In democratic countries where pro-poor laws exist, using legal process and the courts can be a way of building power. It can be a means by which poor people can assert their power over an arm of the state (the judiciary) that is most often used by the rich (but which their taxes also pay for) and make it work in their interests. However, there must be qualifications linked to this approach: it must be accompanied by media, social mobilisation, public education about the legal questions that are being tested, and control by activists of the lawyers they employ and over decisions taken during the legal process.

5.2. Case Preparation

Case preparation is a technical process which requires careful planning and consideration of several practical matters. Time and resources must be spent in preparing the case so a s to mount successful litigation and realise the stated objectives. Thought must be given to the question of the identity and characteristics of the parties, whether as petitioners/plaintiff/claimant/complainant etc and the respondent/defendant etc. Moreover, the evidence collected during research must be analysed, sifted and organised. As the PILCA extract below demonstrates, preparation for case must take an appreciable amount of time and effort.

Excerpt from Christopher Mbazira, Zachary Lomo and Ismene Zarifis **Economic, Social and Cultural Rights Litigation: A Manual for Public Interest Lawyers and Litigators** (2014), Public Interest Law Clinic, School of Law, Makerere University, pp 145 - 155

PLANNING A PIL CASE

6.1. Introduction

Planning a public interest litigation case is critical to its outcome and impact. It is imperative for intending litigants to think strategically what they ought to do before going to court and what they will do after court. For instance, reflect on key issues such as:

a) What is the problem? What does the community say about it? Does the community see it as a problem? Is it a clash of value systems or world views? From which \ world view is this a problem?

b) What are the causes?

c) What material issues does the problem present or rise?

d) How do you proceed? Is this the best course of action? What local alternatives are available?

6.2. Strategy before Litigation & Advocacy

Before the decision to go to court is taken, intending litigants should carry out two key critical set of activities: they should undertake a thorough or 'a-3D', so to speak, diagnosis of the problem and the potential threats or barriers or fears and estimate the level of resistance that they are likely to encounter. This is resistance from those who are more likely to lose directly or indirectly if the litigation is successful. If the litigation is unsuccessful, they should also foresee the reprisals that are likely to occur and how that might exacerbate the situation that the litigation intended to redress.

6.2.1. Thorough Diagnosis of the Problem

A thorough analysis of the problem or situation analysis should at least address the following seven aspects. This list is not exhaustive:

a) Make an objective analysis of the problem in line with the context, vision, and mission of your organisation

This is probably the most crucial facet of the whole PIL planning process. Getting the problem right is key. Understanding the local context in which the problem developed is critical. But determining causes of a given social problem can be challenging, especially in the context of competing world views about everything, from child upbringing, domestic violence, marriage, to sexual choices people make in life. Crucially, differentiating symptoms from cause is critical. What could be a problem from a purely black letter law perspective or other world views, for example, a western world view about children made to work or domestic violence against spouses, women in particular, could be understood as a social responsibility issue whereby parents and the community are duty-bound to inculcate in the child the virtues of work and responsibility, in particular the child needs to learn the hard realities of life, often in the Ugandan context, especially the rural setting. This includes working, for example, in the field or fetching water or collecting firewood, sometimes for hours on long. Distinguishing abuse from proper parental responsibility, including administering punishment to a child is not straightforward because what constitute abuse is one community may not be considered as such in another.

Another illustration could be taken from the world of marriage, in particular domestic violence. Domestic violence has a multiplicity of causes yet activists often seem to treat it as a black and white issue of gender inequality by which they mean women

are always being treated unfairly by men and heaping the blame on patriarchy. Patriarchy is a method of social organisation where the male members of the family and clan are head of that family and authority, thereby discounting the role which women themselves play in defining social rules in almost most societies.

In the case of Africa, something called 'bride price' has been singled out by some western scholars and their local disciples as the main cause of domestic violence and have mobilised resources to get rid of it. Indeed some of the public interest causes that have been litigated in our courts in the recent past have had considerable financial and intellectual support from abroad. That is not to say that local actors cannot collaborate with foreign sympathisers; the critical questions are: what kind of collaboration and who sets the agenda for that collaboration? Who determines what the issues of social justice are? In other words, who determines what is the problem and can defining the problem escape cultural biases? Indeed, as the case of Mifumi demonstrates, domestic violence, whether against women or not, is not caused by one particular factor, so-called 'bride price'. Couldn't 'bride price' simply be a symptom and not cause of domestic violence? How does one explain the levels of violence against women in developed countries where no 'bride price' plays a role in marriage relations?

The observations of some of the Justices of the Constitutional Court in the Mifumi case, discussed in Chapter Four, and Justice Mpagi-Bahigeine's observations, in particular are pertinent this aspect and are quoted in extenso here:

> *I observe that all the deponents of the affidavits in support of the petition concentrated on incidences of domestic violence allegedly consequent upon failure to effect refunds of bride-price. I found this evidence lacking in data. Domestic violence is a worldwide plight to women/men which has received United Nations' attention – The Declaration on the Elimination of Violence Against Women – (General Assembly Resolution 48/104 of 1993) specifically enjoins member states to pursue policies to eliminate violence against women (emphasis supplied). The Domestic Violence Bill is still in the offing, hopefully the Act will soon emerge to take care of the situation. Curiously, violence is more prevalent in countries where the term 'bride-price' is unheard of, with the exception of India, but even in the case of India it is the payment of insufficient dowry by the bride which is the cause of domestic violence and suicide. It is not due to "bride-price" (emphasis supplied).*

This is not to discount the possibility of abuse of a particular cultural practice but an objective analysis of the problem of domestic violence in the community (the Japadola, in the Mifumi case) might reveal intriguing causes that might point to individual weakness and character traits that we are increasingly avoiding to confront and instead heaping blame on States, governmental agencies, and teachers and other social practices.

Thus, the local social justice activist must not only have a thorough grasp of his or her social context but also remain fiercely objective and independent when confronted with the challenge to determine whether a particular problem is indeed a problem within its context. An Activist must not be easily taken in by the allure of the liberal and neo-liberal world, whereby a laissez-faire lifestyle – everything-goes – is packaged and repacked in individualised and legal forms and sold, sometimes enforced through various methods, as the only way human beings on planet earth can live their lives so much so that those other world views they are completely ignorant about are considered backward, uncivilised, or criminals. In the same vein, social justice activists must not be taken in by the romanticised African value system either but must not be afraid to defend what is part of his or her heritage. Every society of human beings has both good and bad attributes and therefore no particular society can claim to dictate to others what is best.

A thorough and objective analysis of the problem will not only allow you to identify the issues and areas of action but also provide the foundation for the ways in which it needs to be solved. With the information from the situation analysis, you can develop a 'problem and solution tree', whereby the 'problem tree' will allow you to understand the causes and the 'solution tree' providing a visual frame of the solutions and their impact on change.

b) Frame the issues, goal(s), and objectives of litigation and advocacy

A party seeking redress through courts of law must allege material propositions of fact and law in order to demonstrate that they have a cause of action or their suit may be dismissed on this aspect alone.

Issues in litigation arise when one party affirms and the other denies a material or material propositions of fact or law. Generally, issues arise once there are disputed questions of fact. At this point, it may be useful to refresh your memory by perusing through the civil procedure rules and the relevant case law on this topic.

Thus, a thorough analysis of the problem should provide some picture of what propositions of fact or law might be asserted and contested if you decide to go to court as the last resort. If the problem is robustly defined and potential issues envisaged, you will have:

i) Separated the facts, good from bad facts;

ii) Devised a strategy for dealing with the facts, in particular the bad facts;

iii) Know how to tell the story;

iv) Envisaged the themes and theories upon which to premise your case in court;

v) Some idea how to prepare for examination of witnesses in court, both examination in chief and cross-examination;

vi) Some idea of what evidence you will need to buttress your case, including the type of witnesses and exhibits.

c) Assess your capacity/competence

Assessing your capacity both in the sense of knowledge and skills and availability of resources to execute a particular public interest litigation suit is paramount. In this respect, some of the key aspects to consider include the following:

i) Legal knowledge and skills
It is imperative that your team of lawyers handling the matter must have the requisite legal knowledge and skills. How does one determine that the team at your organisation has the requisite knowledge and skills to handle the matter at hand? No fast and hard rules but at least three aspects are critical: the complexity and specialised nature of the problem; the training and expertise of the lawyer or lawyers in the field under which the problem fell; and generally, the possession of skills to determine what kind of legal problems are involved in a given situation or scenario.

ii) Maintaining competence
When did members of your team attend the last advanced studies or knowledge and skills improvement courses? If your team comprise people that take seriously the task of maintaining their legal knowledge and skills through continuing legal education seminars and courses, then you have a fairly competent team.

But do not rest on your laurels, you might think of maintaining the competence of your organisation by working in collaboration with experts in the relevant field, including local community experts often ignored or even misunderstood and labelled as part of the problem.

iii) Preparation
Thorough preparation of the case is important, and this requires the capacity or ability to inquire into and critically analyse the factual and legal aspects of the problem at hand.

d) Research

A thorough analysis of the problem, or the situation should provide you with leads on further research to generating evidence for the case. The problem will have generated themes and sub-themes. Frame research questions along these. Next you will have to address where you can find the information you need and who will be undertaking the research. Crucially you will have to determine how you will collect or gather the information or data and analyse it.

e) Identify potential plaintiffs and defendants

Once you know the problems and issues and the best course of action to find solutions, it means you know exactly what you want, and your next challenge is to identify persons in your judgment would make it happen.

Being able to identify who your potential plaintiffs and defendants would be involves your analysing various actors and their powers and grasping how they can advance or undermine your cause.
In analysing who your potential plaintiffs and defendants are and the powers they wield, you may wish to consider some key attributes:

i) Plaintiffs and defendants
These could be individuals, groups, or institutions and your key interest is to establish, for example, who might be most adversely affected, if litigation is successful? Who are likely to gain if litigation is successful or unsuccessful and the subsequent changes that this may usher? Who complains most about the issues?

ii) Interest of plaintiffs and defendants
Having analysed who are likely to be losers and gainers you might want to focus on the specific interests of the potential plaintiffs and defendants. What specific benefits, if any, are likely to be gained by all parties associated directly or indirectly with the problem and litigation to resolve it? What are the expectations of the people for whom this litigation is initiated? Would the plaintiff be interested in participating in the case and thus be willing to contribute some resources to its successful prosecution? The enthusiasm and zeal of the would-be plaintiffs for the cause is critical. What other factors may undermine the enthusiasm of potential plaintiffs to a PIL suit? Consider the democratic credentials of the Ugandan government of the day, in particular with respect to free speech and assembly and access to justice.

f) Determine time frame – how long for

Determining how long for a PIL case will take before the court can pronounce itself on the matter is impossible. Nonetheless, it is imperative that anyone preparing a PIL case should make efforts to estimate how much time is needed to execute the case. Estimating how much time is needed to prosecute the case serves two crucial purposes.

In the first place, it helps inform decision on resource mobilisation and allocation in order to successfully execute the case. In the second place, it is possible to plan an advocacy strategy.

g) Assess amount of resources needed

Mobilising resources, and in particular financial resources, with which to fund the suit is a critical factor to the success of a PIL case and must be planned and thought out clearly. It is important to identify means for fund-raising, keeping in mind that some potential sources, such as philanthropic organisations are often weary of funding PIL suits due to their adversarial nature.

One source of funding could be through legal aid, but in Uganda legal aid is yet far from being implemented and it is doubtful that the government would be willing to

provide legal aid to public interest causes that challenge its policies and practices that undermine the public interest.

In Uganda law schools providing clinical legal education are almost non-existent, save for the Makerere University Law School's newly launched Public Interest Law Clinic, but where they become established, could be one possible source to turn for support in handling a public interest litigation suit.

5.2.1. Gathering evidence

Different cases require different forms and standards of evidence. Some, such as those challenging the constitutionality of a law or laws may be disposed of without necessarily calling for the adduction of evidence. Others may have mixed law and fact issues thus requiring the production of proof, such as in situations where a violation of a right is said to emanate from an act or omission, or where the implementation of a law is said to produce unconstitutional results.

A case claiming discrimination on the basis of ones HIV status may for instance require that one considers the following:

Facts constituting discrimination: In some cases, discrimination may have occurred not as a matter of law but as a matter of fact and the proof of this may suffice to show that a violation has occurred. Evidence may entail documents or witness testimony of facts that prove that the discrimination indeed occurred.

Evidence of unfairness of discrimination: Differentiation or treating people differently in itself is not prohibited by the law and may in some cases constitute permissible discrimination. What is prohibited is unfair discrimination. For one to prove that the discrimination is unfair, evidence must be adduced to prove that the acts constituting discrimination will deny the HIV and AIDS infected/affected person the opportunity to enjoy their rights not only on the same basis as others but also because of their vulnerability.

If the claim relates to the unfairness of a government policy or practice, such as relating to access to some essential services like medicines, one may need adduce evidence that proves:

Unavailability of medicines: This could include evidence that medicines have not been supplied at all, or if supplied, not on time or with the requisite regularity. The supply may also not be of sufficient quantity and quality.

Impact of law or policies on access: In this case, evidence would have to be adduced to prove that the law or policy or its implementation has resulted into or has a potential to deny or reduce access to medicines. This, as seen in Part VII below, was the effect of sections 2, 32 and 34 of the Kenya Anti-Counterfeit Act, 2008 which was challenged in the Asero case.

As is seen in Part VI, GBV cases may require special evidence, i.e. medical evidence to prove for instance that a sexual offence was committed, or that there was an assault, or that violence was meted on the victim.

5.2.2. Using Expert evidence

Expert evidence may be required to prove certain specialised facts, patterns and tendencies such as:

1. *Science of HIV and AIDS*
2. *Social impact of HIV and AIDS and GBV related violations or laws*
3. *Implications of gender on HIV and AIDS and GBVQuality or effects of medicines*
4. *Impact of medical related omissions or commissions*

The South African case of *Hoffman v South African Airways* is an example of how expert evidence in HIV and AIDS cases can be used in litigation.[35] The South African Constitutional Court relied on expert evidence, tendered through an affidavit, to reach some conclusions which had significant implications on the law relating to discrimination in the era of HIV, such as: that an asymptomatic HIV positive person can perform the work of a cabin attendant competently; any hazards to which an immunocompetent cabin attendant may be exposed can be managed by counselling, monitoring, vaccination and the administration of the appropriate antibiotic prophylaxis where necessary; that the risks to passengers and other third parties arising from an asymptomatic HIV positive cabin crew member were therefore inconsequential; and that even immunosuppressed persons were not prone to opportunistic infections and may be vaccinated against yellow fever as long as their CD4+ count remained above a certain level.[36]

Care must be taken to ascertain the quality of expert evidence sought to be relied on. This may be determined by reviewing factors such as:

- ***The qualification of the expert:*** it is critical to ascertain that the expert has a normally recognised training in the relevant field. It is better if the expert qualified from a highly ranked institution since this goes to credibility.

- ***Registration/accreditation:*** the expert may need to be formally registered and/ or accredited as would for example be in the case of doctors.

- ***Experience:*** The more experienced an expert witness is, the more weight is likely to be attached to their evidence.

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[35] Case CCT 17/00 [Constitutional Court of South Africa, 2001 (1) SA 1 (CC).

[36] Para 15.

5.3. Determining the Forum

The forum selected may depend on factors such as the remedy sought, the nature of the complaint, the objective of the litigation, the urgency of the matter, logistical considerations etc. Some courts have special jurisdiction and matters within their competence must only be filed with them. Litigation around HIV and AIDS generally revolves around violation of constitutional rights in which case the most appropriate forum will be determined by reference to article 50 of the Constitution which provides that

50. Enforcement of rights and freedoms by courts.

(1) Any person who claims that a fundamental or other right or freedom guaranteed under this Constitution has been infringed or threatened, is entitled to apply to a competent court for redress which may include compensation.

(2) Any person or organisation may bring an action against the violation of another person's or group's human rights.

Similarly, Article 137 defines the jurisdiction of the Constitutional Court.
Questions as to the interpretation of the Constitution.
(1) …

(3) A person who alleges that—
(a) An Act of Parliament or any other law or anything in or done under the authority of any law; or

(b) Any act or omission by any person or authority,

is inconsistent with or in contravention of a provision of this Constitution, may petition the constitutional court for a declaration to that effect, and for redress where appropriate.

These provisions have been used to determine the jurisdiction of the Constitutional Court in constitutional matters in contrast to that of the High Court. It has been held that the High Court exercises jurisdiction under Article 50, only where the matter is with respect to enforcement of a right in the Bill of Rights and not interpretation. This is where one alleges that their right has been violated or abused and does not seek to annul any law or policy claiming that it is inconsistent with the Constitution. [37] It is only the Constitutional Court which, by Article 137, has the power to interpret the Constitution and annul provisions of other laws found to be inconsistent with the Constitution.

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[37] See Attorney General vs Tinyefunza vs Attorney, Constitutional Appeal No. 1 of 2007. See also Christopher Mbazira Public Interest Litigation and the Struggle Over Judicial Activism in Uganda: Improving the Enforcement of ESCRs, Human Rights & Peace Centre (2008)

By way of illustration, Article 50 and the High Court would be the most appropriate where a person living with HIV alleges that they have been discriminated against by someone's conduct, which could have resulted, for instance, from denial of access to health care, employment of education. However, where the person alleges that the discrimination is a perpetrated by a law or policy of Government, Article 137 and the Constitutional Court would be the most appropriate.

Some quasi-judicial bodies too may exercise some limited or specialised forms of jurisdiction and may thus be approached for redress. For example, under Article 52 of the Constitution, the Uganda Human Rights Commission (UHRC), has powers to investigate and hear complaints of human rights violations. In exercising these powers, the Commission has the powers of a court of law and can make binding orders.[38] The UHRC has powers to provide redress to persons who allege that any of their rights have been violated by anyone, including government and private persons and entities.

The Equal Opportunities Commission (EOC) can be approached where one alleges that their right to enjoy equal opportunities has been violated or abused. The Equal Opportunities Commission Act defines "equal opportunity to mean the same treatment or consideration in the enjoyment of rights and freedoms, attainment of access to social services, education, employment, and physical environment or the participation in social, cultural and political activities regardless of sex, age, race, colour, ethnic origin, tribe, birth, creed, religion, health status, social or economic standing, political opinion or disability.[39] On the basis of this, persons living with or affected by HIV and/or AIDS can approach the EOC for redress where they allege denial of equal opportunity.

As is further illustrated in Part VI, victims of GBV can also approach magistrate's courts for civil claims. Where crimes are alleged to have been committed, victims may lodge complaints with appropriate prosecutorial authorities such as the Police and the Directorate of Public Prosecutions to have eh matter investigated and prosecutions mounted

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[38] See also the Uganda Human Rights Act, Chapter 24 Laws of Uganda.

[39] Section 1, Equall Opportunities Commission Act, Act No. 2 of 2007.

PART VI

THE QUESTION OF REMEDIES

6.0. Introduction

The outcome of the case is as good as the process. Many times, when people go to court, they seek to bring about change. This could be change in the form of legal reforms, annulment of laws that violate rights, stopping ongoing or potential violations, or seeking relief and redress for violations which have occurred for which injury has been suffered. In all these cases, it is important to have a clear strategy and to carefully consider the remedy one wishes to obtain and how best to present arguments for this before court.

6.1. Understanding Remedies

(Excerpt) Christopher Mbazira, Zachary Lomo and Ismene Zarifis **Economic, Social and Cultural Rights Litigation: A Manual for Public Interest Lawyers and Litigators** (2014), Public Interest Law Clinic, School of Law, Makerere University, pp 145 - 155

CHAPTER EIGHT
Remedies

8.1. Introduction

One of the most important and yet least discussed subjects in PIL is the subject of remedies. Remedies constitute the ultimate outcome of litigation and are in many respects crucial in determining the ultimate outcome of a case. Many times, litigants come to court to seek relief and have their positions reversed in cases where infraction complained of has changed their position or be put in the position which they are entitled to be in by virtue of their legal rights. Indeed, the law on remedies is one of the growing areas of constitutional law and one in respect of which courts have acted in pragmatic and innovative ways. At the same time however, the law on remedies in some jurisdictions remains stark and requiring urgent development. Indeed, the subject of remedies is an area of PIL that lawyers need to pay close attention to. It does not serve any purpose to win a case on the merits yet get a bad remedy or no relief at all. Equally so, it does not make sense to get a good remedy, but which is never implemented.

The purpose of this Chapter is to introduce public interest lawyers in Uganda to the subject of remedies and provide guidance on some of the remedies which are available in PIL and how they can be used. The Chapter explores the different remedies available in constitutional litigation, how they can be used and the distinctions between constitutional remedies and other forms of remedies. Reference is made to comparative jurisdictions which have experimented with different remedies.

The remedial powers and approach of the courts in Uganda in constitutional matters is also discussed and challenges in this regard highlighted. Suggestions are made on how implementation of remedies can be realised.

8.2. Types of Remedies

There are various types of remedies which have been used in litigation. A remedy can be defined as the ultimate direction issued by a court of law after hearing a case on its merits and making a decision on the same. In some cases, remedies may be available in the course of the hearing before the case is heard and decided on its merits. Traditionally, the courts have used damages as the only form of relief that could atone for injury suffered, even when the injury was not pecuniary. Later, as a product of the development in the law arising among others from the law of equity, new remedies such as injunctions started to emerge. Unfortunately, in many jurisdictions the law has not adequately grown, and particularly in constitutional litigation, to embrace the use of both "new" and traditional remedies in a creative manner. It is against this background that this section sets out the different types of remedies and how these have been used in constitutional litigation to provide redress for particularly human rights violations.

8.2.1. Damages

It should be noted, however, that as popular as damages are, they may in some cases when used in their traditional manner be inappropriate in those cases involving the violation of fundamental rights and freedoms. In the first place, the basis of damages is an economic theory, which presupposes that the deterrent effect of remedies arises from the fact that damages will always outweigh the benefits to be derived from engaging in the prohibited conduct. Unfortunately, in reality, this may not be the case. In some cases the benefits to be derived by the violator may be hard to express in monetary terms. Yet, the non-monetary benefits to be derived from the violation may be so important to the violator to outweigh the threat of damages.

The most important shortcoming with damages however is the fact they may not be able to atone for the violation of human rights. Loss of dignity, honour and integrity arising from a violation may be impossible to restore using money, irrespective of the level or quantum of damages.

One creative way of using damages as a remedy in public interest litigation is to ensure that the damages decreed instead of going into the pockets of the few litigants who are able to make their way to court actually go to improving the conditions which cause the violation. Courts have for instance been urged to experiment with what are called preventive damages, which are damages that are given to bodies carrying out activities that are intended to deter infringements of the nature complained about. One formula that could guide court in determining damages of this nature is by considering the cost of deterrence.

8.2.2. Declarations

Declarations are the most commonly sought-after relief in constitutional litigation and feature prominently in cases of a public interest nature. A declaration is an uncomplicated relief by which a court pronounces itself and gives clarification on the proper interpretation or position of the law, or even answers a legal question put to it. The value of declarations is that they clear doubts on legal issues surrounded with uncertainty and help to determine whether a particular decision or conduct is in accordance with the law. Declarations are popular because they seat well with those who glorify the separation of powers doctrine and detest the idea of another organ giving directions to other organs demanding that something is done. For judicial officers who are sensitive regarding the extent to which they can intrude into the affairs of other organs of state, declarations is the first resort. Similarly, from the perspective of courts, declarations may be effective remedies in cases where there are several options open to the respondent (especially the state) of remedying the violation. The declaration would save the court from the agonising burden of selecting among several approaches. This is a task the court would rather leave to the respondent and concentrate on declaring the existence of an illegality or breach of duty.

From the perspective of legal practitioners however, the question is one of when it may be appropriate to seek for a declaration in preference to other forms of relief. In some cases, the law prescribes a declaration as the only available relief. In other cases, the presentation of a declaration as the only form of relief as a matter of legal practice, sometimes in a manner that curtails the ability of courts to be creative with remedies. This, as is illustrated latter, has been the case in Uganda in constitutional petitions.

Ugandan lawyers may want to learn from the creative manner in which comparative jurisdictions have coupled declaration with other creative remedies in order to make constitutional litigation meaningful. In the African context, South Africa offers interesting lessons. The South African Constitution allows the courts to enforce the rights by granting petitioners “appropriate relief, including a declaration of rights” (section 38). The courts are also empowered in deciding constitutional matters to declare that any law or conduct that is inconsistent with the Constitution is invalid to the extent of the inconsistency. However, the courts are in this regard empowered to limit the retrospective effect of the order of invalidity and may make an order suspending the declaration of invalidity for a specified period. The courts have taken full advantage of these powers to make declarations which are not only meaningful but which in appropriate cases avoid creating a lacuna in the law. To achieve this, the courts have declared pieces of legislation invalid but while suspending their orders of invalidity by allowing the legislation to continue in use for a stated period of time, within which the legislature should have addressed the inconsistency.

8.2.3. Injunctions

Injunctions, referred to as interdicts in some jurisdictions, are the most authority remedy in the arsenal of courts used to compel litigants to carry out desired actions or refrain from engaging in undesired conduct. Thus, an injunction can be defined as an order of court requiring the person to whom it is directed to do or refrain from doing a particular thing. In this respect, the injunction serves a dual purpose: first, as a remedy for those whose rights have been violated ordering restitution or restoration and second, as a remedy to deter future violations or end on-going violations. Originating from equity, the injunction has taken different forms. Prohibitory injunctions are negative orders that prohibit the person or persons to whom they are directed from doing something considered unlawful. In contrast, the mandatory or prescriptive injunctions are expressed in positive terms and require the person(s) to whom they are directed to do something the court deems desirable for the purpose of protecting existing rights or remedying violations which have occurred. One could also speak of perpetual/permanent and interim/temporary injunctions. The permanent injunctions are orders that endure in perpetuity and have a permanent impact. They could include orders that permanently bar someone from engaging in certain conduct. In contrast, temporary injunctions help to maintain the status quo, in most cases, until the final dispute is determined by the court. This could serve the purpose of protecting people's rights as disputes regarding their enjoyment are determined.

The most innovative, and sometimes controversial of the injunctions, and one slowly being embraced by some jurisdictions is the structure injunction. The excerpt below describes this of form of injunction and how it is used. In some jurisdictions structural injunctions are referred to as structural interdicts.

There are different types of structural injunctions. One common feature though is that in all the cases the court retains jurisdiction and if necessary may supervise implementation of the remedy. The courts retain what has been described as supervisory jurisdiction. The different types and models include: The Bargaining Model, under which the court gives the parties the opportunity to negotiate the remedy, and once agreed is reached the court decrees the remedy. The Legislative/ Administrative hearing model involves the creation by the court of a legislative like committee which at public hearings entertains views from interested parties on the most appropriate remedies and recommends the same to the Court. The Expert Remedial Formulation Module involves the appointment by the court of an individual or panel of experts to advice on the most appropriate remedy.

It is important for Uganda lawyers to understand the benefits which have been derived from the structural injunction and to be pushing the courts to embrace this form of relief in deserving cases. The different types of this form of relief and their various benefits should be appreciated and experiment with in appropriate cases.

Powers and Approach of the Uganda Judiciary

This section briefly explores the constitutional provisions that define the remedial powers of the Uganda courts in constitutional matters and the approach which the courts have adopted. The right to remedy in respect of human rights violations can in the first place be deduced from Article 50 which entitles any person who thinks that their rights have been violated to approach the court for redress. The provision also defines locus standi in an expansive manner that allows persons or organisations taking action for the violations of rights of third parties:

50. Enforcement of rights and freedoms by courts.

(1) Any person who claims that a fundamental or other right or freedom guaranteed under this Constitution has been infringed or threatened, is entitled to apply to a competent court for redress which may include compensation.

(2) Any person or organisation may bring an action against the violation of another person's or group's human rights.

As seen above, Article 50(1) uses the word "redress" is a broad and an implicit reference to a wide array of remedies that would bring about redress. Reference to "compensation" is used only for emphasis. This means that the courts have wide discretion and are not in any way constrained in terms of the remedies they may grant.

Article 137(3) which defines the remedial powers of the Constitutional Court equally grants the Court unlimited discretion as regards the types of remedies it may decree.

137. Questions as to the interpretation of the Constitution.

(1) …

(3) A person who alleges that—

(c) an Act of Parliament or any other law or anything in or done under the authority of any law; or

(d) any act or omission by any person or authority,

is inconsistent with or in contravention of a provision of this Constitution, may petition the constitutional court for a declaration to that effect, and for redress where appropriate.

The provision above gives the Court wide discretion to in addition to a declaration craft remedies that provide appropriate redress. This means that the Constitutional Court is not restricted to making declarations of invalidity where an Act of Parliament or anything done under the authority of law if found to be inconsistent with the Constitution. Unfortunately, the Constitutional Court has not taken full advantage

of the remedial discretion which the law has accorded it. The Court has applied its remedial powers narrowly, in most cases by simply declaring legislation or conduct unconstitutional, without exploring the other remedies. An example of this is the case of Law Advocacy for Women in Uganda v Attorney General - Constitutional Petitions Nos. 13 /05 /& 05 /06. In this case, the Petitioners contested the constitutionality of the provisions of the Succession Act and those of the Penal Code Act, which discriminated against women. Section 154 of the Penal Code Act created the offence of adultery but discriminated against women in the sense that a married woman committed the offence when she had sexual intercourse with another man not being her husband, while a man committed the offence only if the woman was married. The state conceded to the unconstitutionality of the provision but invited the court rather than strike it out to read it in a manner which removes the inconsistency. Rejecting the submission, the Court held that under Article 137(3) of the Constitution, the Court is only required to declare whether or not an Act of Parliament or any other law or anything done under authority of any law or any act or omission by any person or authority is inconsistent with or is in contravention of the provisions of the Constitution. That the Court is also enjoined to grant redress where appropriate but is not mandated to modify a law which it has found to be inconsistent or in contravention with the provisions of the Constitution.

In its ruling above, the Constitutional Court defines its remedial powers in very restrictive manner and fails to take advantage of the wide discretionary powers the Constitution gives it to craft remedies. Although the Court was not prepared to make use of its wide discretionary powers in this particular case, it should have done so without putting a caveat on its powers. It is therefore important for lawyers to push the Court to get away from this approach and to appreciate the importance of preserving its wide remedial powers. One of the strategies for achieving this is through extensive use of comparative jurisprudence to illustrate how courts have taken advantage of their powers and actually done the things which the Court has declined to do.

8.4. The Challenge of Implementation

One of the biggest challenges in the area of remedies is the question of implementation of court orders. It is one thing to win a case and secure a court order and another to have the court complied with by the person against whom the order is made. There are various reasons why court orders may not be complied with, these include:

- *Ambiguity of orders*
- *Obstinacy, disrespect of courts and disregard for rule of law*
- *Incapacity to implement orders*
- *Absence of coordination in implementation*
- *Absence of complimentary factors*

In some cases, the court orders are crafted in ambiguous terms, which make it hard for the persons to whom they are directed to understand what is required of

them. The excerpt below illustrates some of the challenges which may emerge from ambiguous orders.

In cases of this nature, it may be necessary to go back to court and seek for clarification. At the same time, however, one has to guard against those cases where ambiguity is given as an excuse by an obstinate party. Obstinacy is sheer stubbornness and refusal to abide by the orders of court. In some cases, obstinacy is brewed from impunity and the failure to recognize the legitimacy of the court order or the entire court structure. An example of sheer obstinacy and disrespect for the rule of law is seen in the excerpt below:

In cases of obstinacy, it may be necessary to devise ways of inculcating the culture of respect of rule of law. This is a process that may require more than legal strategies but political action beyond the scope of this manual. Nonetheless, the use of international mechanisms may in legalistic terms contribute to building such culture.

There are also those cases where the effective implementation of the court order requires the coordination of various entities. This may be so in those cases involving a multiplicity of government agencies with varying roles or at different levels of government and across sectors. In some cases, the complexities of coordination may not have been noticed or considered at the time of crafting the court order. In these cases, would be important for the lawyers to appreciate these complexities and to work them out in a manner which helps the court craft an order that clearly stipulates the roles of the different entities required to implement the same.

In some cases, the court in itself may be insufficient to change the situation unless complimented by other strategies. Indeed, it is important that all cases litigation is complimented by such other strategies as advocacy, and in some cases social mobilisation may be necessary.

(Excerpt) **Centre for Health, Human Rights and Development, Digest on the case of Center For Health, Human Rights and Development & Ors v Executive Director Mulago Hospital & Ors,**
Civil Suit No. 212 Of 2013 [High Court Of Uganda] (May 2017)

In setting the stage for her approach to the remedies, Justice Mugambe-Ssali uses provisions of General Comment No. 22 of the Committee on Economic, Social and Cultural Rights on Reproductive and Sexual Health Rights to the effect that States must ensure that all individuals have access to justice and to a meaningful and effective remedy in instances where the right to sexual and reproductive health is violated. Having found that the 2nd and 3rd Plaintiffs suffered psychological torture and that the state violated the right to health as well as the right of access to information, the Judge awarded damages of UGX 85,000,000.

One of the most interesting aspects of this case are the consequential orders which Justice Mugambe-Ssali made. These are reproduced below:

(i) The police must conclusively investigate the disappearance of the baby of PW1and PW2 in issue and file a report on the same in court within 6 months from the date of this judgment at the latest.

(ii) Ms. Mandida Mariam the midwife who handled the baby at birth must be held to account for the movement of the baby from her care.

(iii) Mulago hospital shall take steps to ensure and/or enhance the respect, movement and safety of babies, dead or alive, in its facilities.

(iv) For two years from the date of this judgment the 1st Defendant shall make written reports, every four months, regarding the steps or measures taken in fulfilling (iii) above and serve the same on the 1st Plaintiff.

(v) The 1st Plaintiff shall have free access to Mulago hospital and continuously oversee the implementation of the measures in (iii) above and make counter reports on their effectiveness or otherwise within two months from the date of receipt of the 1st Defendants reports.

(vi) The 1st Plaintiff shall ensure that the 2nd and 3rd Plaintiffs access psycho-socio care and counseling services as part of their healing. Mulago hospital shall pay for any attendant costs in this regard.

(vii) The 2nd and 3rdPlaintiffs are awarded Ug. Shs: 85,000,000/=(Eighty five million only) as general damages for the psychological torture, violation of their rights to health and access to information resulting from the disappearance of their baby at Mulago hospital.

As a matter of fact, the above consequential orders did not form part of prayers made by the plaintiffs in their plaint. However, the Judge deemed these appropriate because in her view she looked at the infractions against the 2nd and 3rd Plaintiff as being widespread and arising from a systemic problem in Mulago Hospital as far as the handling newborns, dead or alive is concerned. The question that could be posed is one of whether a judge is entitled to adopt this approach. To understand the Judge's approach and its justification, it is important to understand the conceptual remedial approaches that are available to judges. It is important to note that global jurisprudential trends show that judges are slowly discarding their traditional role as neutral arbiters and have for the sake of justice and human rights acted in more pragmatic ways. In the area of choosing remedies, this trend could be understood by understanding the influence of "corrective justice" and "distributive justice" objectives. Corrective justice is very much concerned with dealing with cases on a case-to-case basis and focuses mainly on correcting what has gone wrong for the benefit of those before court. It is not only bipolar but is also backward-looking, to the extent that it focuses on the parties before court and only interrogates previous conduct, with limited concern on the parties' future behaviour and its impact on persons not before court. The purpose of this form of justice is to restore the victim of a violation, as

practically as is possible, to the position they would have been in had the violation not occurred. Where restoration is impractical, damages are the preferred relief.

In contrast, distributive justice is more concerned with the distribution of benefits and burdens among members of a given group. From a legal perspective, proponents of this form of justice view courts as instruments for using the law to ensure the distribution of benefits and burdens in an equitable manner. This among others the courts do by focusing beyond the parties and placing a particular case in a wide perspective that consider the needs and wider interests of society. This form of justice is more forward looking and could among others consider the implications of the conduct of any of the parties on other persons or actors, beyond those in court.

The approach which Justice Mugambe-Ssali chose is primarily in line with the distributive justice approach and was intended to deal with the systemic problem of loss of newborns and baby bodies at Mulago Hospital. It is this same approach that motivated the Judge to issue a structural injunction by requiring the Police and Mulago Hospital to report back to court with respect to compliance with the directives given to them.

A structural injunction is a relatively new remedy in Uganda. This is an order that defies the doctrine of functus officio, which is a doctrine to the effect that once a judge has issued judgment in a matter, they cease having jurisdiction over the same, unless it comes back to them in the exceptional circumstances of review. The structural injunction has been used in some jurisdictions including the United States of America, India and South Africa to among others enable judges to monitor the implementation of their orders. The most common form has been for the courts to require parties to report back to them on the measures taken to implement the orders. In Uganda, the structural injunction has recently been approved and applied by both the Constitutional Court and the Supreme Court.

The question though is whether these remedial approaches are in line with the powers of judges in Uganda. This question can be answered by examining some provisions of the Constitution of Uganda.

6.2. Remedies at the African Regional Level

It is important to note that there are mechanisms within the African Union that can be used to obtain remedies in HIV and GBV cases. Like other regions, the African system has a vibrant human rights system, defined by human rights instruments, complete with enforcement procedures and mechanisms.

6.2.1 The African Commission on Human and Peoples Rights

The African Charter on Human and Peoples Rights creates the African Commission on Human and Peoples Rights as the body empowered to monitor implementation of the Charter. The Commission has powers to receive and consider complaints

filed against states by those who allege violation of the rights protected by the Charter. These complaints are referred to as "communications". The Commission has established a practice of considering these complaints and giving rulings with recommendations, which are transmitted to the African Union and forwarded to the state concerned. It should be noted, however, that the Commission only entertains complaints filed after exhausting local remedies. This means that the complainant must have tried to obtain remedies from domestic judicial system in vain. There are exceptions such as if the remedies are unduly prolonged or are unavailable. In addition to exhaustion of local remedies, the Charter describes additional prerequisites of a communication as is indicated below:

African Charter on Human and Peoples Rights
(Adopted 27 June 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), entered into force 21 October 1986)
Article 56

Communications relating to human and peoples' rights referred to in 55 received by the Commission, shall be considered if they:

1. Indicate their authors even if the latter request anonymity,

2. Are compatible with the Charter of the Organization of African Unity or with the present Charter,

3. Are not written in disparaging or insulting language directed against the State concerned and its institutions or to the Organization of African Unity,

4. Are not based exclusively on news discriminated through the mass media,

5. Are sent after exhausting local remedies, if any, unless it is obvious that this procedure is unduly prolonged,

6. Are submitted within a reasonable period from the time local remedies are exhausted or from the date the Commission is seized of the matter, and

7. Do not deal with cases which have been settled by these States involved in accordance with the principles of the Charter of the United Nations, or the Charter of the Organization of African Unity or the provisions of the present Charter.

6.2.2. The African Court on Human and Peoples Rights

This court was established by the Protocol to the African Charter on Human and Peoples Rights on the Establishment of the African Court on Human and Peoples Rights. The Arusha, Tanzania based Court, is empowered to receive cases against states parties alleging the violation of the rights protected in the African Charter, its protocols and other human rights instruments ratified by the state. Unlike the

Commission which makes recommendations, the African Court makes binding decisions. One major drawback is , that individuals and NGOs can only access the Court if the state in which they are based have made a declaration allowing them to do so. This snag does not affect the Commssion though since it can file a case against any member state without having to deal with that hindrance. The excerpt below gives some basic information about the court.

Protocol to the African Charter on Human and Peoples Rights on the Establishment of the African Court on Human and Peoples Rights

Adopted by the African Union on 10th June 1998

…

Article 3 JURISDICTION

1. The jurisdiction of the Court shall extend to all cases and disputes submitted to it concerning the interpretation and application of the Charter, this Protocol and any other relevant Human Rights instrument ratified by the States concerned.
2. In the event of a dispute as to whether the Court has jurisdiction, the Court shall decide.

…

Article 5 ACCESS TO THE COURT

1. The following are entitled to submit cases to the Court

a. The Commission;
b. The State Party which has lodged a complaint to the Commission;
c. The State Party against which the complaint has been lodged at the Commission;
d. The State Party whose citizen is a victim of human rights violation;
e. African Intergovernmental Organizations.

2. When a State Party has an interest in a case, it may submit a request to the Court to be permitted to join.

3. The Court may entitle relevant Non-Governmental Organizations (NGOs) with observer status before the Commission, and individuals to institute cases directly before it, in accordance with article 34 (6) of this Protocol.

…

Article 34 RATIFICATION

6. At the time of the ratification of this Protocol or any time thereafter, the State shall make a declaration accepting the competence of the Court to receive cases under article 5 (3) of this Protocol. The Court shall not receive any petition under article 5 (3) involving a State Party which has not made such a declaration.

7. Declarations made under sub-article (6) above shall be deposited with the Secretary General, who shall transmit copies thereof to the State parties.

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