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**LAW AS A TOOL:
THE CHALLENGE OF HIV/AIDS IN
UGANDA**

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Introduction

This paper aims to explore, with particular reference to Uganda, the role of human rights law in addressing the HIV/AIDS epidemic. In doing so, it may also contribute to debates concerning: a) the role that law can play in rehabilitating or preventing the formation of ‘crisis’ states; and b), more generally, the usefulness of law in addressing major development issues.²

It is important to clarify that the emphasis here is on law as a tool, not as the tool, since the impact of law is always either constrained or facilitated by other factors – social, political, and economic.³ A wide interpretation of ‘human rights law’ is also employed, incorporating issues such as the rights of women and children to non-discrimination and protection from abuse. This paper does not employ the interpretation favoured by some writers on HIV/AIDS, in which ‘human rights’ in the context of this epidemic seems to apply mainly, or even exclusively, to the rights of people living with HIV/AIDS. It has been written primarily from a legal perspective, drawing on expertise regarding the function and operation of both national and international law.

Uganda is selected as the ‘case study’ here in part because it is widely regarded as a country that has succeeded, perhaps more than any other country in sub-Saharan Africa, in reducing the rate of HIV/AIDS prevalence in its population. It is considered to have achieved this largely through a combination of civil society initiatives, governance, and aid from international donors. The perception generally is that law has not been a feature of this strategy (although Uganda has ratified the key international human rights treaties and has a Constitution that reflects this).⁴ This paper examines whether law was in fact insignificant in

¹ With many thanks to my very able research assistants Claire La Hovary (London), Sydey Letuu Etima (Uganda 2004) and Susanne Okeny (Uganda 2005). Thanks, too, to my hostess in Uganda, Flora Nkurukenda, and her family.

² On the role of human rights law in relation to HIV/AIDS generally, and the reasons why HIV/AIDS is seen as a development challenge, see Jenny Kuper, ‘Law as a Tool: The Challenge of HIV/AIDS’, Background Paper, Crisis States Research Centre, 2005, at <http://www.crisisstates.com/download/projectnotes/kuper.pdf>. On the topic of law and development, see, for example, Kevin E Davies & Michael J Trebilcock, ‘Legal Reforms and Development’, *Third World Quarterly*, 22:1 (2000), pp.21-36; Francis G. Snyder & Peter Slinn, (eds), *International Law of Development: Comparative Perspectives*, Abingdon: Professional Books, 1987; and Balakrishnan Rajagopal, *International Law from Below: Development, Social Movements and Third World Resistance*, Cambridge: Cambridge University Press, 2003.

³ Certainly poverty is one of the key determinants in the spread of HIV/AIDS. See, for example, Eileen Stillwaggon, ‘HIV/AIDS in Africa: Fertile Terrain’, *The Journal of Development Studies*, 38:6 (2002), pp.4-7 & 17-18.

⁴ The literature on Uganda’s HIV/AIDS strategy emphasises factors such as behaviour change, political commitment, and community participation. See, for example, Janice Hogle (ed.), *What Happened in Uganda? Declining HIV Prevalence, Behaviour Change and the National Response*, Washington: USAID, 2002, p.12; and Justin Oliver Parkhurst, *HIV Prevention Policy in Sub-Saharan Africa: The Ugandan Experience* (Thesis), Oxford: St Antony’s College, 2002, pp.306-309. See also Tim Allen & Suzette Heald, ‘HIV/AIDS Policy in

Uganda's apparent success, and will look at a number of related questions, including whether legal reform could have an impact on the current situation or whether it is indeed marginal.

Uganda is also relevant in that it can, to some extent, be categorised as a 'fragile' or 'crisis' state, in that its "political or economic system is confronted with challenges with which existing institutions and organisations are potentially unable to cope".⁵ This is particularly evident in the long lasting and continuing conflict in the north of the country, and sporadic conflict in the Rwenzori region in the west. These conflicts, combined with almost two decades of unrest and/or armed conflict from around 1966 to 1986 (when the current government took power), have had a profound social and economic impact on the country. The conflicts in the two decades prior to 1986, in particular, have been described as having "severely damaged the country's law enforcement infrastructure", leading to ineffective implementation of laws and contracts.⁶ These conflicts have, moreover, contributed to a lack of social cohesion (which is one of the key determinants for the spread of HIV/AIDS).⁷

Other factors also contribute to the categorisation of Uganda as a 'crisis state'. For example, growing corruption⁸ and 'excessive red tape', combined with the weak legal infrastructure, are perceived as causing further difficulties, such as hindering foreign investment. In the mid-1960s the Ugandan health care system was one of the finest in Africa, but has been weakened by war and economic decline. Uganda remains one of the poorest countries in the world,⁹ and this inevitably predisposes a large sector of the population to HIV vulnerability.¹⁰ It is also home to a large mobile and displaced population including many orphans and other vulnerable children. Indeed, Uganda has the world's youngest population, and the third highest population growth rate (a factor that puts pressure on the economy and the health service).¹¹ High fertility means that the Ugandan population is likely to continue increasing substantially, to over 115 million by 2050 (although the population may be up to 11 percent smaller than with a 'no AIDS' scenario).¹² It is also one of the least urbanised countries in Africa, with over 80 percent of its population in rural areas.¹³

This paper starts by briefly outlining relevant aspects of the HIV/AIDS situation in Uganda. It then explores the claim regarding Uganda's HIV/AIDS success particularly in two respects:

Africa: What Has Worked in Uganda and What Has Failed in Botswana?' *Journal of International Development*, 16 (2004), pp. 7-12.

⁵ Crisis States Programme (CSP), 'Concepts and Research Agenda', *Crisis States Working Paper*, 1, London: Crisis States Research Centre, LSE, April 2001, p.1.

⁶ Lisa Garbus & Elliot Marseille, *Country AIDS Policy Analysis Project: HIV/AIDS in Uganda*, San Francisco: AIDS Policy Research Centre, University of California San Francisco, 2003, p.7.

⁷ See Tony Barnett & Alan Whiteside, *Aids in the 21st Century: Disease and Globalization*, Hampshire & New York: Palgrave Macmillan, 2003, pp.129-136.

⁸ Uganda ranks 105th out of 146 countries (146th country being the most corrupt). Transparency International, *Corruption Perception Index*, Berlin: Transparency International, 2004, p.4, at http://www.transparency.org/cpi/2004/dnld/media_pack_en.pdf.

⁹ 38% of the population lives in absolute poverty with children constituting 62% of the poor (Ministry of Gender, Labour & Social Development, *National Orphans and Other Vulnerable Children Policy: Hope Never Runs Dry*, Kampala: Ministry of Gender, Labour and Social Development, 2004a, p.1, (hereafter National OVC Policy).

¹⁰ The high rate of parasitic and other diseases in tropical regions such as Uganda is also a factor. See, for example, Stillwaggon (2002).

¹¹ UNDP, *Human Development Report 2004*, New York: UNDP, 2004, p. 154.

¹² Garbus & Marseille (2003), pp.7-8 and 10. These writers also point out that military expenditure as a percent of GDP exceeds health expenditure.

¹³ Uganda AIDS Commission, *The HIV/AIDS Epidemic: Prevalence and Impact*, Kampala: Uganda AIDS Commission, 2003.

has it indeed been a ‘success’; and was law marginal? The second section then examines whether – if indeed law was marginal – this is still the case. Are there areas where lack of law, or inadequate law, has become a problem? If so, what is being done to address this? The final section concludes by briefly linking the Uganda study to the underlying theme of ‘crisis states’, development and law, before making some recommendations regarding possible legal reform in Uganda.

Background and Key Questions

HIV/AIDS in Uganda

The first cases of HIV/AIDS in Uganda were identified in 1982, along the shores of Lake Victoria in the Rakai District. The disease quickly spread to other parts of the country and national HIV prevalence rates increased, reaching an estimated 9 percent in 1987-88, and peaking at 18.3 percent by the end of 1992 (with some regions reaching a prevalence rate of over 30 percent), before declining between 1993 and 1998.¹⁴

Despite the acknowledged decline in sero-prevalence rates, the mechanisms that produced this are not fully understood.¹⁵ Nonetheless, it is generally accepted that a combination of interventions adapted to the situation in Uganda led to a reversal of high prevalence rates in many areas of the country.¹⁶ In particular, one writer identifies the key interventions as including a comprehensive strategy based on behaviour change, combined with high-level political commitment and a diverse spectrum of community-based participation.¹⁷ It is worth noting that these interventions also incorporated the notion of “care, support and recognition of the rights of people living with HIV/AIDS”.¹⁸

By 2002, the overall national antenatal HIV prevalence rate had diminished to an estimated 6.2 percent, though with wide variations between, for example, rural and urban sites (5.1 and 7.9 percent respectively), with the highest rate being recorded in Lacor hospital in Gulu, in the strife-ridden north (11.9 percent).¹⁹ The most consistent HIV prevalence declines were among those aged 15 to 24, although in the 15 to 19 age group the prevalence rate for females was, over the years, apparently between two and six times higher than among males.²⁰ In 2005, 7.9

¹⁴ Uganda Aids Commission, *HIV/AIDS in Uganda: The Epidemic and the Response*, Kampala: Uganda Aids Commission, 2002. Although there is some disagreement about the precise figures, there is broad agreement regarding the trajectory of peak and decline, and its timing. See, for example, Justin Oliver Parkhurst, ‘The Ugandan Success Story? Evidence and claims of HIV-1 prevention’, *The Lancet*, 360:9326 (6 July 2002b), p.78; Garbus & Marseille (2003), p.6; and Robert Basaza & Darlison Kaija, ‘The Impact of HIV/AIDS on Children: Lights and Shadows in the “Successful Case” of Uganda’, in Giovanni Andrea Cordia (ed.), *AIDS, Public Policy and Child Well-Being*, Florence: UNICEF, 2002, pp.6-8, at http://www.unicef-icdc.org/research/ESP/aids/aids_index.html.

¹⁵ Government of Uganda, Uganda AIDS Commission, Joint United Nations Programme on AIDS & Other Stakeholders in HIV/AIDS, *The National Strategic Framework for HIV/AIDS Activities in Uganda: 2000/1 – 2005/6*, Kampala: Government of Uganda, March 2000, (NSF), p.i. See also Parkhurst (2002a), pp.15 and 315-316.

¹⁶ See, for example, Susheela Singh *et al.*, *A, B and C in Uganda: The Roles of Abstinence, Monogamy and Condom Use in HIV Decline*, New York and Washington: The Alan Guttmacher Institute, 2003; Hogle (2002), pp.2-11; and UNAIDS, *2004 Report on the Global AIDS Epidemic*, Geneva: UNAIDS, 2004, pp.72-73.

¹⁷ Hogle (2002), p.12. See also Parkhurst (2002a), pp.306-309.

¹⁸ Garbus & Marseille (2003), p.6.

¹⁹ STD/AIDS Control Programme, Ministry of Health, *STD/HIV/AIDS Surveillance Report*, Kampala: Ministry of Health, 2003, p.9.

²⁰ Garbus & Marseille (2003), p.6. See also STD/AIDS Control Programme (2003), pp.17-23, and Uganda AIDS Commission, *Uganda National Aids Policy - Final Draft*, Kampala: Uganda AIDS Commission, 2004b, p.1.

percent of Ugandan women in general were estimated to have HIV compared to 6 percent of men.²¹ In any event, in 2004 it was estimated that since the late 1990s the decline appears to have stagnated at a “national high level of 6 percent over the last 2-3 years, with slight increases in some areas”.²² A more recent (May 2005) estimate indicates that 7 percent of adult men and women are infected with HIV, with a prevalence of 10.7 percent in urban and 6.4 percent in rural areas.²³

Despite the apparent decline, HIV/AIDS continues to have a huge impact on Uganda. For example, while in 2000 Uganda had 0.4 percent of the world’s population, it had 2.4 percent of the global HIV/AIDS cases.²⁴ By the end of 2003, the total number of people aged under 49 living with HIV/AIDS was estimated at 530,000 (out of a population of almost 27 million). Of these, 450,000 (or 85 percent) were ‘adults’ aged 15-49, of whom 270,000 were women.²⁵ By 2000, 1.3 million people were said to have died in Uganda as a result of AIDS,²⁶ and in 2003 alone, there were 78,000 AIDS-related deaths.²⁷ Apparently “heterosexual HIV transmission accounts for 75-80 percent of the total new infections” while mother-to-child transmission including breastfeeding accounts for 15-25 percent and use of infected blood products and transmission in health care settings accounts for 2-4 percent.²⁸ By 2005, single, widowed mothers and elderly widowed grandmothers were the predominant heads of household.²⁹ At the end of 2003, the number of children below 14 living with HIV/AIDS in Uganda was estimated at 84,000,³⁰ and the infant mortality rate increased from 97 per 1000 live births in 1988-92 to 101 per 1000 live births in 2000. Overall life expectancy decreased from 48 in 1990 to 42 in 2000.³¹ AIDS is now the leading cause of death in Uganda amongst adults and the fourth highest cause of death amongst children under five.³²

One of the many devastating effects of HIV/AIDS is the enormous number of orphans and “orphans-in-the-making”.³³ By 2002, nearly 2.5 million children under 18 in Uganda had lost at least one parent (and were therefore defined as orphans), of which 351,074 had lost both.³⁴

²¹ Major General (Rtd) Jim Muhwezi, M.P., Minister for Health, *Press Release on 2nd May 2005: Preliminary Results of the Uganda HIV/AIDS Sero-Behavioural Survey*.

²² Uganda AIDS Commission (2004b), p.1.

²³ Muhwezi (2005).

²⁴ Basaza & Kaija (2002), p.4.

²⁵ See UNAIDS, UNICEF, WHO, Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, Uganda 2004 update, p.3 (http://www.who.int/GlobalAtlas/PDFFactory/HIV/EFS_PDFs/EFS2004_UG.pdf, accessed on 7 June 2005).

²⁶ Garbus & Marseille (2003), p.6.

²⁷ UNAIDS, UNICEF, WHO (2004), p.3

²⁸ Uganda Aids Commission (2002).

²⁹ See e.g., UNAIDS general country information, available at <http://www.unaids.org/EN/geographical+area/by+country/uganda.asp>, accessed on 24 Jan. 2005.

³⁰ UNAIDS (2004), pp.190-193.

³¹ Basaza & Kaija (2002), p.4.

³² Uganda Aids Commission (2002).

³³ Angela Wakhweya *et al.*, *Situation Analysis of Orphans in Uganda – Orphans and their Households: Caring for Their Future – Today*, Uganda: Government of Uganda and Uganda AIDS Commission, 2002. For definition of orphans in Uganda, see Executive Summary and p.6. Regarding orphans affected by HIV/AIDS generally, see Barnett & Whiteside (2003), pp.196-213.

³⁴ Uganda Bureau of Statistics, *2002 Uganda Population and Housing Census – Main Report*, Uganda: Mar. 2005, p.66 (which also estimates that 713,471 had lost only their mother, and 1,433,945 had lost only their father. There was also a large cohort of children where it was unknown if the parent was alive or not). 80% of ‘double’ orphans in Uganda are attributable to HIV/AIDS (Ministry of Gender, Labour and Social Development, *National Strategic Programme Plan of Interventions for Orphans and Other Vulnerable Children, Fiscal year 2005/6-2009/10* (Plan of Interventions for OVCs), Uganda: Ministry of Gender, Labour and Social Development, Nov. 2004c, p.15).

It is estimated that 25 percent of households in Uganda are caring for orphans,³⁵ and this is likely to remain a significant phenomenon for many years, given the very many people in Uganda who currently are living with HIV/AIDS, and the high fertility rates and projected population increase.

Was the Ugandan Strategy a Success?

According to a 2004 UNAIDS report, Uganda “remains the pre-eminent example of sustained success”, and “one of [the] most inspiring examples of an effective national response”.³⁶ Another source states that “there is consensus in the global HIV/AIDS community that there has been a robust decline in HIV prevalence in Uganda”.³⁷

However, while a decline in prevalence is generally acknowledged, there has been some criticism of the much-publicised claim that Uganda reduced the overall HIV prevalence rates from 30 percent to 10 percent, since these decreased prevalence rates (often attributed to Uganda as a whole) apparently occurred only at one site (although rates also fell sharply elsewhere).³⁸ It has also been argued that the impetus to overstate Uganda’s HIV/AIDS success came from a need to maintain the high level of donor funding, and to counter low morale in the health sector.³⁹ Moreover, some studies claim no direct link has been established between Ugandan government strategy and the decline in HIV prevalence rates. One factor challenging a simple cause-and-effect explanation here is the presence of many hundreds of non-governmental, religious, and other organisations that are also working to prevent HIV/AIDS in Uganda (though this has been encouraged by the government). Further, individuals can change their behaviour for reasons unrelated to intervention programmes, for example as a result of awareness of the effects of HIV/AIDS on their friends and families.⁴⁰

In any event, it is significant that the Minister for the Presidency’s Foreword to the 2004 Uganda National Aids Policy states that:

HIV prevalence rates are stabilising at an unacceptably high level in the wake of observed complacency especially at the individual level, attributed to information fatigue and a false sense of security from reports of declining trends.⁴¹

Recent documents on HIV/AIDS in Uganda, and interviews with a number of experts in the country, reveal widespread concern about the apparent stagnation in the decline of HIV prevalence rates.⁴² At the Third HIV/AIDS Partnership Forum in Kampala in November

³⁵ Wakheweya, Kateregga, *et al.* (2002), p.4.

³⁶ UNAIDS (2004), p.13 and p.72.

³⁷ Garbus & Marseille (2003), p.5.

³⁸ See James Putzel, ‘The Politics of Action on AIDS: a Case Study of Uganda’, *Public Administration and Development*, 24 (2004), pp.19-30, p. 25; and James Putzel, *Institutionalising an Emergency Response: HIV/AIDS and Governance in Uganda and Senegal: a report submitted to the Department for International Development*, London, May 2003, pp.7-9. See also Parkhurst (2002b), p.78, where he also stresses the importance of not confusing incidence rates with prevalence rates. Further, he points out that he found his interviewees had differing views as to whether the Uganda AIDS strategy was a success (Parkhurst (2002a), p.302) - as did the author in her 2004 and 2005 interviews.

³⁹ Parkhurst (2002b), p.80.

⁴⁰ Parkhurst (2002b), p.79. See also Government of Uganda *et al.* (2000), p.12, citing evidence of changing practice regarding widow and child inheritance, as community members become aware that these traditions expose them to the risk of HIV/AIDS infection.

⁴¹ Uganda AIDS Commission (2004b), p.i.

⁴² See, for example, Uganda AIDS Commission (2003); Government of Uganda *et al.* (2000), p.ii; and interviews in 2004 with, among others, Joseph Musoke, Executive Secretary, and Titus Twesigye, Information

2004, this issue was repeatedly raised, not least by President Museveni, who gave the official opening speech.⁴³ This Forum also identified certain key factors that to some extent account for the current stagnation.⁴⁴

High on the Forum's list were a number of issues concerning the situation of women and children. This is not to underestimate the impact of HIV/AIDS on men in Uganda, and a number of those involved in HIV/AIDS policy on all levels both within and outside Uganda emphasise that it is essential to work with males as partners in the struggle to contain the epidemic.⁴⁵ There is some evidence of change in male sexual conduct, particularly in the younger generation, and certain cultural traditions are beginning to be questioned.⁴⁶ A woman interviewed in Kampala in 2005 complained of the unjustified "vilification of the African male" in the context of some HIV-AIDS studies.⁴⁷

Nevertheless, both women and children are at particular risk of HIV/AIDS.⁴⁸ This is largely due to a combination of biological and socio-economic factors, along with certain cultural practices (some more widespread than others).⁴⁹ This paper therefore focuses specifically on some of the strategies that could contribute to addressing the issue of the impact of HIV/AIDS on women and children.⁵⁰

To return to the some of the factors identified in the Third HIV/AIDS Partnership Forum as regards the particular vulnerability of women and children in Uganda, these included:

- the situation of orphans, described by one of the speakers as "the most urgent concern".⁵¹ Orphans and other vulnerable children are seen as both a result and a cause

Officer, Uganda Network of AIDS Service Organisations (UNASO), and Dr. Hitimana-Lukanika Charles, Executive Director, AIDS Information Centre (AIC). One study concludes that current "very high" HIV prevalence rates are "grossly affecting child welfare and the national economy" (Basaza & Kaija (2002), p.66).

⁴³ Uganda AIDS Commission, Office of the President, *Forum Report: Reporting the Present Preparing the Future; The 3rd HIV/AIDS Partnership Forum 29-30 November 2004*, Kampala: Jan. 2005, see e.g. pp.7 and 9.

⁴⁴ Other writers have identified further challenges that contribute to the current stagnation in HIV prevalence. For example, Garbus & Marseille (2003), p.14, identify: difficulties in reaching rural populations, youth, mobile populations and conflict areas; human rights deficiencies, and the increasing care and support burden.

⁴⁵ Kuper (2005), p.18; Government of Uganda *et al.* (2000), p.12; and the *Tool Kit* of The Parliamentary Standing Committee on HIV/AIDS (2004), pp.226-229.

⁴⁶ Statistics indicate that the median age of first sex for both Ugandan young men and women increased between 1995 and 2000-2001 (Garbus & Marseille (2003), p.9), and again between 2000-2001 and 2004-2005 (May 2005 Press Release). Further, a representative of one Ugandan NGO stated in a 2005 interview that some young men they had surveyed had reservations about certain cultural traditions, including 'wife inheritance'.

⁴⁷ Interview in April 2005, name withheld. She specifically questioned the sweeping nature of some observations made in the Human Rights Watch report *Just Die Quietly: Domestic Violence and Women's Vulnerability to HIV in Uganda*, New York, Human Rights Watch, 2003.

⁴⁸ Kuper (2005), pp.13 & 18.

⁴⁹ In identifying these cultural factors, the intention is not to impose a simplistic 'Northern' critique of customary practices. The crucial point here is that a number of cultural practices have been identified as contributing to the spread of HIV/AIDS in Uganda and other countries, and that it is Ugandans themselves who are now increasingly voicing criticisms of these practices and proposing change.

⁵⁰ The paper uses the agreed definition – both in international and Ugandan domestic law – of children as generally being those aged under 18. See Kuper (2005) p.29; 1996 Ugandan Constitution (Art. 257(1)). However, in Uganda, as in many other countries, there is a substantial gap between international and national legal norms, and practice 'on the ground' especially in rural areas where customary norms still largely prevail. See, for example, Refugee Law Project, 'Child Protection in the Context of Displacement: Ntoroko County, Bundibugyo District', *Refugee Law Project Working Paper*, 13, Kampala: Refugee Law Project, Dec. 2004, pp.11-12.

⁵¹ Uganda AIDS Commission, Office of the President (2005), p.10. See also Putzel (2003), p.43.

of the continuing HIV/AIDS prevalence.⁵² Many of them have been orphaned by HIV/AIDS or its consequences. They can find themselves socially excluded; living in child-headed households; and facing malnutrition, lack of immunisation and health care, lack of schooling, and early entry into marriage or the world of work. Some suffer from depression as a result of witnessing the prolonged illness of their family members; and they may be vulnerable to sexual abuse, especially if they find themselves homeless, for example as a result of the practice of ‘property grabbing’ (the unlawful seizure of their property by relatives or others in the community).⁵³ They can thus be at risk of both contracting and spreading HIV/AIDS;

- the particular vulnerability of young people generally. For instance, one speaker at the 2004 Forum referred to the fact that it is necessary to target those in the 10-24 age range who are sexually active but not yet married, since studies show that the average age of first sex is around 17, but the average age of marriage (male and female) is around 22.8.⁵⁴ Indeed, the majority of Ugandan girls apparently have their first pregnancy while still in their teens.⁵⁵ There is also the problem that in the 15-19 age range, girls experience a substantially higher rate of HIV infection than boys. This is generally attributed to the fact that they are often in relationships with older men who may be (knowingly or unknowingly) already infected with HIV, and that many men seek relationships with very young women partly because they are seen as less likely to be infected;
- “gender inequities”,⁵⁶ due largely to the subordinate socio-economic status of women and certain cultural practices that contribute to this in areas such as marriage, divorce and inheritance. Some of the factors identified here include the practice of ‘wife inheritance’ (for example by the husband’s brother on the death of the husband); wife sharing; the payment of ‘bride price’; polygamous marriages (in 2003 about 32 percent of Ugandan women were in a polygamous union)⁵⁷; female genital mutilation and early marriage, as well as male preference in the inheritance of land and other property.⁵⁸ For example, at the 2004 Forum it was specifically mentioned that over 60 percent of HIV-positive women in Uganda are infected within marriages where they are faithful but their husband is not.⁵⁹ Early marriage is also a significant issue in that there are a surprisingly high number of these, despite the fact that Ugandan law

⁵² For definition of ‘vulnerable children’, see e.g. The *Tool Kit* (Parliamentary Standing Committee on HIV/AIDS (2004), p.199).

⁵³ See Garbus & Marseille (2003), p.11; Basaza & Kaija (2002), pp.34-50; and Ministry of Gender, Labour and Social Development (2004a), p.3. Barnett & Whiteside (2003), pp.211-213, point out that orphanhood renders children particularly vulnerable to violations of various rights to which they are in principle entitled under the 1989 Convention on the Rights of the Child (CRC).

⁵⁴ Uganda AIDS Commission, Office of the President (2005), p.10. It was also stated here that early sexual debut is usually without the benefit of correct condom use, and quite often the result of rape or ‘defilement’.

⁵⁵ Figures cited in the NSF indicated that by the age of 19, 63% of girls had had a pregnancy, and, of females pregnant for the first time, 43% were teenagers (Government of Uganda *et al.* (2000), p.11).

⁵⁶ Uganda AIDS Commission, Office of the President (2005), p.10.

⁵⁷ Garbus & Marseille (2003), p.8.

⁵⁸ For a summary of some of these factors, see e.g. the NSF (Government of Uganda *et al.* (2000), p.12); Ministry of Gender, Labour and Social Development, *The National Action Plan on Women*, Kampala: Ministry of Gender, Labour and Social Development, 1999, p.19, and Wendy L. Patten & Andrew J. Ward, ‘Empowering Women to Stop AIDS in Côte d’Ivoire and Uganda’, *Harvard Human Rights Journal*, 6 (1993), pp.210-221.

⁵⁹ Uganda AIDS Commission, Office of the President (2005), p.10. Some writers describe a cultural environment in Uganda where male assertiveness and conquests are considered a sign of virility, whereas women are expected to be faithful and submissive. See e.g., Basaza & Kaija (2002), p.15, and Government of Uganda *et al.* (2000), p.12. As pointed out in a 2004 interview by Catherine Watson, Editorial Director of Straight Talk Foundation, such pressures can be harmful to both boys and girls.

prohibits marriage (and indeed sexual relationships) of girls under 18. The 2002 Ugandan Census (published in 2005) records that the total number of 10-14 year-olds in monogamous marriages was 69,502, while there were 421,590 in the 15-19 age range. In polygamous marriages, the numbers were 5,486 and 44,809 respectively (the vast majority of whom of course were girls).⁶⁰ At the 2004 Forum, one speaker emphasised that early marriages were being encouraged in Uganda: “despite the fact that research showed that being married might not necessarily mean being faithful to one partner and thus not a plausible solution especially considering the number of women getting infected in monogamous marriages”.⁶¹ One problem in attempting to eliminate the practice of early marriage is that there are often strong economic incentives for it.⁶²

Thus the Ugandan HIV/AIDS strategy has been a success in some respects, although there is uncertainty about the extent of the achievement and exactly how it has come about. Certainly on visiting the country it is difficult not to be impressed by the energy, initiative and commitment of many of those working on this issue. Nonetheless, the HIV/AIDS success is limited to some extent, as indicated by the stagnation (or indeed slight increase) at about 7 percent in the previously declining rates of HIV prevalence. Further, there are a number of factors particularly affecting women and children that contribute to this stagnation.

Was Law Marginal?

During the initial nine years of the National Resistance Movement (NRM) government (from 1986 to 1995) the Ugandan HIV/AIDS strategy was almost entirely policy-based. As one writer points out, in the Ugandan context the term ‘policy’ does not necessarily mean written policy. Rather, a conceptualisation of ‘policy’ can be used where this term does not simply refer, for example, to that which is documented in reports and plans, but “includes those actions undertaken by the state to achieve its ultimate goal – in this case HIV prevention efforts reaching as wide a range of the population as possible”. These policies can be “unwritten or indirect”.⁶³

The adoption of the revised Constitution in 1995 – and the presence of certain other pieces of national and international legislation – did mean that some of the policy initiatives undertaken to address HIV/AIDS, especially post-1995, had an implicit legal underpinning. However, to date the Ugandan HIV/AIDS strategy has largely functioned outside the arena of directly applicable formal law.

1. Policy Highlights: Summary

Initially, in the years between 1982 (when the first cases were identified) and 1986 (when the NRM came to power), the HIV/AIDS epidemic was addressed in Uganda largely through the health sector (such as it was), and by spontaneous community interventions. In 1986, the government established the Uganda National AIDS Control Project, focussing on blood safety, prevention of HIV infection in health care settings, and education and

⁶⁰ See Ugandan Bureau of Statistics (2005), p.50.

⁶¹ Uganda AIDS Commission, Office of the President (2005), p.22.

⁶² For example, early marriage means not only that the bride’s family has one less mouth to feed, but also has additional bride price income (Refugee Law Project study (2004), pp.22-24).

⁶³ See Parkhurst (2002a), pp.296 and 299.

communication.⁶⁴ Further, it created AIDS control projects in twelve line ministries, and by 2003 all government ministries had HIV/AIDS work plans.

In 1987, the Ministry of Defence established an AIDS Control Programme in response to the special needs of the armed forces, and in that same year the AIDS Support Organisation (TASO)⁶⁵ – now a large and influential organisation – was officially established to provide psychosocial support to those living with or affected by HIV/AIDS. The AIDS Information Centre was formed in 1990, providing the first confidential voluntary testing and counselling services in Uganda. In 1992, the government adopted the Multisectoral Approach to the Control of AIDS (MACA),⁶⁶ and established the Uganda AIDS Commission to coordinate the nationwide activities of the various actors involved in MACA, and to mobilise resources.⁶⁷ The Uganda National Programme of Action for Children (UNPAC) was also initiated in 1992, under the auspices of which the National Council of Children was established in 1996.⁶⁸ Further, 1996 saw the adoption of the Universal Primary Education Policy, aiming to provide free and compulsory primary education, and specifically including orphans.

Then came the Ugandan ‘National Strategic Framework for HIV/AIDS Activities’ (developed initially in 1997 and revised in 2000) – described as “a key document positioning HIV/AIDS as part of country’s broader national development”.⁶⁹ In 1997, Uganda also initiated a decentralisation policy, which encouraged local government to help implement the strategic framework and develop HIV/AIDS interventions specific to their local context (although apparently by 2003 most districts had not yet developed HIV/AIDS work plans). In September 2003 there were said to be as many as 2,500 NGOs working on HIV/AIDS in Uganda.⁷⁰

Increasingly there have been attempts to place the HIV/AIDS problem in the broader context of national development and relate it to national policies on health and poverty eradication, for example through the Poverty Eradication Action Plan (PEAP), and Vision 2025.⁷¹ Further,

⁶⁴ Garbus & Marseille (2003), p.11, and Basaza & Kaija (2002), p.20. For analysis of the early initiatives, see Putzel (2004), pp. 23-25, and Putzel (2003), pp. 15-27.

⁶⁵ TASO was originally set up by 16 volunteers, at the instigation of an HIV/AIDS widow who identified the need to address stigmatisation of people with HIV. The core activity of TASO is counselling, and assisting clients to practice a code of conduct including ‘positive living’. It also provides some medical care for its clients. (Interview with Ann Kaddumukasa, Public Relations Officer, TASO. Jan. 2004.)

⁶⁶ Garbus & Marseille (2003), p.11.

⁶⁷ See Putzel (2003), pp.29-30 & 51-52, for a critical appraisal of this Commission.

⁶⁸ See e.g. Basaza & Kaija (2002), pp.52-53 for further information on UNPAC and the National Council for Children. There are many other policies that directly or indirectly relate to children, as outlined in Ministry of Gender, Labour and Social Development (2004c), p.11.

⁶⁹ Garbus & Marseille (2003), p.11. See also Uganda AIDS Commission, *Twenty years of HIV/AIDS in the world: Evolution of the Epidemic and Response in Uganda*, Kampala: Uganda AIDS Commission, June 2001, generally. The NSF was again updated under a Mid-Term Review of activities implemented between 2000/1 and 2003, leading to a revised strategy for 2003/4-2005/6 (Republic of Uganda & Uganda AIDS Commission, *The Revised National Strategic Framework for HIV/AIDS Activities in Uganda 2003/04-2005/06: A Guide for all HIV/AIDS Stakeholders*, Kampala: Uganda AIDS Commission, 2004).

⁷⁰ Garbus & Marseille (2003), p.11. A major role is played in the Ugandan HIV/AIDS strategy by local and international NGOs, community-based organisations, and faith-based organisations. In 1996 these bodies formed a national network, UNASO (Uganda Network of AIDS Service Organisations), to coordinate their work (Basaza & Kaija (2002), p.27).

⁷¹ PEAP has four main aims: to improve the quality of life for the poor; economic growth for poverty reduction; good governance, and increased ability of the poor to raise incomes (Basaza & Kaija (2002), p.33). Vision 2025 was the result of a ‘visioning exercise’ involving the Ugandan population and key stakeholders through a representative system, and formulating a vision statement of national aspirations, popularly summarised as: ‘prosperous people, harmonious nation, beautiful country’.

a National Monitoring and Evaluation Framework of HIV/AIDS activities in Uganda has recently been established.⁷²

Three policy documents of particular relevance to this paper are those on: a) HIV/AIDS; b) orphans and other vulnerable children, and c) women. In 1993, the HIV/AIDS policy document was developed under the auspices of the Uganda AIDS Commission. It was revised in 1996 and a long-awaited recent version, setting out a number of proposed legislative measures, was finalised in 2004.⁷³ According to a representative of the Commission, the 2004 policy document was, in April 2005, awaiting Cabinet agreement, but in the meanwhile it was being acted on as accepted policy by those working on HIV/AIDS issues in Uganda.⁷⁴ In 2004, another important policy document – the National Orphans and Other Vulnerable Children Policy – was also finalised. By the end of 2004 this had been approved by the Cabinet, but was yet to be formally distributed and operationalised.⁷⁵ Among other things, this Policy has as one of its guiding principles that orphans should be treated “as actors in their own right”, thereby emphasising the importance of not treating them as helpless victims.⁷⁶ The National Action Plan for Women was developed in 1999, and was later expanded to include legal framework and decision-making as one of its priority areas.⁷⁷

Since the late 1980s, government, NGOs, activists and others have generally promoted the ‘ABC’ strategy: abstain; be faithful; use condoms.⁷⁸ In the early stages of this campaign, Museveni and some religious leaders opposed condom use, but by the mid-1990s they had generally abandoned open opposition,⁷⁹ and one study maintains that there developed a policy of ‘quiet promotion’ of condoms.⁸⁰ That said, the promotion of condom use remains to some extent controversial in Uganda even in 2005, particularly as regards young people.⁸¹

Another strand of the Ugandan government’s strategy was to facilitate public sensitisation on ‘ethics and human rights’ of those infected and affected by HIV/AIDS, in order to reduce their stigmatisation and discrimination.⁸² One writer describes the effort made to reduce stigma as part of the indirect and unwritten policies that were unique to the Ugandan HIV/AIDS response, and stresses that a sensitive topic such as sexual behaviour required a

⁷² Republic of Uganda & Uganda AIDS Commission, *The National Monitoring & Evaluation Framework for HIV/AIDS Activities in Uganda. 2003/4-2005/6*, Uganda: Republic of Uganda and Uganda AIDS Commission, Aug. 2004.

⁷³ Ministry of Gender, Labour and Social Development (2004a), pp.11-17.

⁷⁴ Interview with Kindyomunda Rosemary Mwesigwa, Head NADIC, Uganda AIDS Commission, April 2005.

⁷⁵ Uganda AIDS Commission, Office of the President (2005), p.24.

⁷⁶ Ministry of Gender, Labour and Social Development (2004a), p.6.

⁷⁷ Ministry of Gender, Labour and Social Development, *Guidelines for Monitoring and Evaluating Implementation of the National Action Plan on Women*, Kampala: Ministry of Gender, Labour and Social Development, 2004b, pp.1, 11-14 and 20-21. See the *National Action Plan for Women*, (Ministry of Gender, Labour and Social Development (1999), p.17) for a summary of the legal impediments faced by women in Uganda.

⁷⁸ Singh *et al.* (2003), Executive Summary.

⁷⁹ Garbus & Marseille (2003), p.11.

⁸⁰ See Parkhurst (2002a), p.309.

⁸¹ See, for example, comments made by Museveni at the 3rd HIV/AIDS Forum (Uganda AIDS Commission, Office of the President (2005), p.7); and Human Rights Watch, *The Less They Know the Better: Abstinence-only HIV/AIDS Programs in Uganda*, New York: Human Rights Watch, 2005. However, the recent *Tool Kit* (Parliamentary Standing Committee on HIV/AIDS (2004), p.90) categorically states that condom use is a key measure to prevent HIV transmission.

⁸² Uganda AIDS Commission (2002), p.5.

sensitive government approach.⁸³ Nonetheless, apparently much remains to be done as regards discrimination and stigmatisation of those living with HIV/AIDS in Uganda.⁸⁴

The current Ugandan HIV/AIDS strategy has been summarised to include:

public information campaigns, research, voluntary testing and counselling, safe blood transfusions, school health programs, home-based care for people living with AIDS, and a broad campaign to treat STDs.⁸⁵

One study argues that the local councils, introduced by the NRM government in 1986, were very active in the late 1980s in promoting behaviour change. They are said to have reasserted patriarchal interests, sometimes hearing cases where HIV/AIDS-infected people (usually women) were accused of witchcraft and even, on occasion, ordering their execution.⁸⁶ This kind of response represented a form of legal (or quasi-legal) intervention on the local level, but it was obviously out of step with developing national policy – though it illustrates the complexity of the Ugandan national response to HIV/AIDS.

2. Why Policy?

Given that the key initiatives undertaken by the Ugandan government to address the HIV/AIDS epidemic between about 1986 and 1995 were primarily policy-based, one question that arises is: why was law not a more central feature of these initiatives? In fact, there were obvious reasons for this reliance on policy. In particular, as already mentioned, the nearly two decades of armed conflict in Uganda prior to 1986 had inevitably undermined its legal infrastructure, as well as many other aspects of government. Despite this chaotic situation, Museveni – apparently shocked when a large percentage of army officers sent to Cuba for military training were found to be already infected with HIV/AIDS – did seem to quickly respond to the threat posed by this epidemic, openly acknowledging it and encouraging others in his government to do likewise.⁸⁷

Although it was clearly a formidable task to simultaneously confront a growing HIV/AIDS pandemic and rebuild a (largely) post-conflict country, in some respects that challenge facilitated the formulation of a coherent HIV/AIDS policy. As one writer points out, in Uganda in 1986 “the NRM had to establish itself in the context of a society torn apart by conflict”, and much of what the NRM government did was “the coping strategy of a weak state with little economic base and few political options”. The NRM was in a ‘unique’ position to shape national responses and rebuild the health infrastructure. It could only unite

⁸³ Parkhurst (2002a), p.309.

⁸⁴ See Basaza & Kaija (2002), p.27, and comments made by interviewees in Kampala, such as Ann Kaddumukasa, Public Relations Officer, TASO (Jan. 2004). See also UNAIDS, *HIV and AIDS-Related Stigmatisation, Discrimination and Denial: Forms, Contexts and Determinants - Research Studies from Uganda and India*, Geneva: UNAIDS, 2000, pp.28-34.

⁸⁵ Lisa Ann Richey & Stine Jessen Haakonsson, ‘Access to ARV Treatment: Aid, Trade and Governance in Uganda’, *DIIS Working Paper*, 19, Copenhagen: DIIS, 2004, p.30.

⁸⁶ Allen & Heald (2004), pp.10-11. According to a 2000 study (UNAIDS (2000), p.31), some rural communities in Uganda still regard HIV/AIDS as associated with witchcraft and curses, leading to ostracism of those infected with the virus.

⁸⁷ See Putzel (2004), pp. 23-25. See also Garbus & Marseille (2003), pp.11-12, and Uganda AIDS Commission, *The Story of AIDS in Uganda ... And banana trees provided the shade*, Kampala: Uganda AIDS Commission, 2004a, pp.7-8.

people by incorporating all groups and designing a system that minimised the chances of sectarian splits.⁸⁸ Another writer stresses that in Uganda:

unity behind the HIV/AIDS campaign was achieved in part due to the overwhelming presence of President Museveni and his military organisation, given the context of the guerrilla war he had won ...[T]he absence of effective political competition in the late 1980s allowed leaders to spearhead a nationwide campaign on HIV/AIDS almost overnight without needing to be overly deferential to potential opponents of the strategy.⁸⁹

By 1986, many people in Uganda already knew that a lethal illness was wiping out members of their families and communities, and they were eager for knowledge and strategies to cope with this. Apparently by the time national HIV/AIDS programmes were underway in Uganda in 1987-88, experience of something like AIDS, and high mortality rates, were already widespread in places. “Particularly in the south of Uganda, people were well aware that something was wrong”, so that “there was evidence to back up the early awareness and behavioural change campaigns”.⁹⁰

In these circumstances the more conventional role of law could be filled by policy. One international lawyer formulates the link between law and health-related issues as follows: “because health education is a slow process, law is often used as a shortcut, to lay down norms of healthy behaviour and to provide for their enforcement”.⁹¹ Arguably, in Uganda, particularly between 1986 and 1995, the ‘shortcut’ of formal legal rules and institutions was not necessary to fulfil this role as regards HIV/AIDS, given that there was a strong and uniform government policy with few competing institutions or credible political opponents, and that people were already motivated to act by the growing evidence of the epidemic they were confronting. Moreover, the reality was that in Uganda at that time there was extremely limited capacity to engage in the lengthy business of law making. In fact, what was needed, and what was created, was an ‘emergency response’.⁹² It is therefore arguable that HIV/AIDS policy in Uganda since 1986 has had a quasi-legal character, and indeed to some extent this remains the case even in 2005.

The Legal Landscape

Formal Law and Uganda’s HIV/AIDS Strategy

Having concluded that formal law was generally marginal to the Ugandan HIV/AIDS strategy – at least between 1986 and 1995 – this section considers whether, post-1995, such law remained marginal. I find that the country has, in the last decade, taken tentative steps towards transforming aspects of its HIV/AIDS-related policy into formal law. It also finds that in Uganda there is – and was even prior to 1995 – a body of law related to HIV/AIDS, but most such law is indirectly relevant (although nonetheless significant) in the sense that it aims to

⁸⁸ Parhkurst (2002a), pp.90 and 317.

⁸⁹ Putzel (2003), pp.24 and 39.

⁹⁰ Allen & Heald (2004), p.7. See also Putzel (2003), p.25, who points out that politicians also had experienced the impact of HIV/AIDS in their own families

⁹¹ Katarina Tomasevski, ‘Why a human rights approach to HIV/AIDS makes all the difference’, London: Overseas Development Institute, 2005, p.2

⁹² See Putzel (2003), p.4, and comments made by Museveni at the 3rd HIV/AIDS Forum (Uganda AIDS Commission, Office of the President (2005), p.7).

regulate human behaviour in key areas such as divorce, marriage, family life and inheritance. As stated elsewhere:

law has a particular importance in the context of HIV/AIDS, due to the nature of the virus and the fact that it is spread and can be controlled by regulating human behaviour – which is one of the main functions of law.⁹³

Indeed, one of the key features of law is that it provides both a platform for claiming entitlements, and for framing strategies to implement them in the future.

1. Pertinent Factors: Social Values, Law and Institutions

The process by which social values can be transformed into law can be seen as the passage of claims from the status of *de lege feranda* (law as ought to be) to *lex lata* (law as it is). It is characterised by the ‘emergence of values’, i.e. of new ideas hardening into values that become increasingly important to the point where ‘social feeling’ develops to formally sanction them – and this marks the threshold of law. The claim must then be defined in legal terms to become formal law. Law is accordingly seen as dynamic and ever changing to reflect social realities and evolving norms, and as responsive to perceived deficiencies in the existing law.⁹⁴ However, the absence of formal legal status does not necessarily deprive a moral claim of its force. According to Sengupta, the UN ‘Independent Expert on the Right to Development’, legislation that converts a ‘valid’ right into a ‘legal’ right is one procedure to make an agreement honoured, but need not be the only one: “Even if a right cannot be legislated, it can still be realized if an agreed procedure for its realization can be established”.⁹⁵

In fact, after 1986 the evolution of the HIV/AIDS response in Uganda clearly illustrates both these trends. On the one hand, some HIV/AIDS-related principles articulated as policy have crystallised into formal law, or are on the threshold of doing so, as will be discussed below. On the other hand, certain HIV/AIDS-related entitlements (for example, to receive information, education, and some medical assistance) have, as policy, nonetheless been treated as ‘valid’ rights that should be honoured.

However, to this day Uganda still has no explicit HIV/AIDS legislation, including legislation on the rights of people living with or affected by HIV/AIDS. Nor does Ugandan law enshrine a right to health as such, although the right to the “highest attainable standard of ...health” is set out in international treaties that Uganda has ratified.⁹⁶

Moreover, legal processes in Uganda are severely hampered by factors such as high levels of corruption, lack of resources, and poverty – a context in which the legal system is seen as largely inaccessible and unaffordable.⁹⁷ This is clearly problematic, since law can only be as

⁹³ Kuper (2005), p.35. See also pp.6-7, which clarify that the law under consideration in this paper is the framework of substantive measures represented by national and international rules and their implementation mechanisms, as opposed to the concept of ‘rule of law’.

⁹⁴ Kuper (2005), pp.5-6.

⁹⁵ Commission on Human Rights, *The Right to Development, Second Report of the Independent Expert on the Right to Development*, UN Doc.E/CN.4/2000/WG.18/CRP1 (11 Sept. 2000) para. 9.

⁹⁶ See, for example, the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR), Art. 12, and the 1989 CRC, Art. 24. The ‘right to health’ also arguably forms part of international customary law (see Andrew Clapham & Mariano Garcia-Rubio, *The Obligations of States with Regard to Non-State Actors in the Context of the Right to Health*, Geneva: Health and Human Rights Working Paper Series, OMS, 2002).

⁹⁷ Regarding problems with judicial corruption in Uganda, see Abdullahi Ahmed An-Na’im, ‘Protecting Human Rights in Plural Legal Systems of Africa: A Comparative Overview’, in Abdullahi Ahmed An-Na’im (ed.),

effective as the individuals and institutions that administer and enforce it. Some writers argue that reforms in substantive areas of law, such as human rights law, are less effective in furthering development than reforms that improve the quality of institutions that enact, administer and enforce such law.⁹⁸ Certainly these two strands are inextricably linked – although it seems self-evident that, even if the institutional aspect has a greater impact, both are important in creating a robust legal system.

In any event, legal developments in Uganda relevant to HIV/AIDS do thus unfold in the context of a lack of explicit HIV/AIDS legislation, and deficiencies in the legal infrastructure.

2. International Treaties

Certain significant legal developments did take place, nonetheless, and it is of note that 1995 marked Uganda's ratification not only of its revised Constitution, but also of three key international human rights treaties: the International Covenant on Civil and Political Rights (ICCPR) and its Optional Protocol (which allows individuals to complain to the UN Human Rights Committee⁹⁹), as well as the International Covenant on Economic, Social and Cultural Rights (ICESCR).¹⁰⁰ Further significant ratifications of international treaties followed, including the two Optional Protocols to the 1989 Convention on the Rights of the Child (1989 CRC): one (in 2001) on the sale of children, child prostitution and child pornography; and one (in 2002) on the involvement of children in armed conflict. The 1989 CRC had already been ratified in 1990.

Prior to this, Uganda had ratified other important international human rights treaties, including those providing for the rights of migrant workers (ratified in 1995); prohibiting torture and other inhuman treatment (in 1986); prohibiting discrimination against women (in 1985); and prohibiting racial discrimination (in 1980).¹⁰¹ As regards regional law, the country ratified, in 1986, the African Charter on Human and Peoples' Rights;¹⁰² in 2001, its Protocol establishing an African Court on Human and Peoples' Rights; and, in 2004, the African Charter on the Rights and Welfare of the Child.

Universal Rights, Local Remedies: Implementing Human Rights in the Legal Systems of Africa, London: Interights, 1999, p.54. He also highlights that the use of English in Ugandan higher courts contributes to their inaccessibility (p.45). One local study vividly illustrates problems with corruption in the police and lower courts, particularly in cases concerning children (Sophie Witter, George Calder & Timothy Ahimbisibwe, *Taking Better Care? Review of a Decade of Work with Orphans and Vulnerable Children in Rakai, Uganda*, London: Save the Children, 2004, pp.21, 35-36, & 46). See also Lynn Khadiagala, 'Uganda', in Herbert M. Kritzer (ed.) *Legal Systems of the World: A Political, Social, and Cultural Encyclopaedia, Vol. IV*, Santa Barbara, Oxford: ABC Clio, 2002, pp.1675-1681, who states (p.1680) that Museveni has undermined confidence in modern law "by criticising both actors and processes" as, *inter alia*, remnants of a colonial past.

⁹⁸ See Davies & Trebilcock (2000), pp.21 & 32-33.

⁹⁹ Kuper (2005), p.32.

¹⁰⁰ These events were probably linked, in that adoption of the 1995 Constitution facilitated the passage into Ugandan law of the ICCPR and the ICESCR ratified earlier that year. Uganda is a country that requires enabling legislation to implement international obligations in national law. (See Kuper, 2005, n.127; and Antonio Cassese, *International Law*, Oxford: Oxford University Press, 2001, pp.166-171).

¹⁰¹ International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families; the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW); the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, and the International Convention on the Elimination of All Forms of Racial Discrimination, respectively.

¹⁰² The 1981 African Charter on Human and Peoples' Rights (Art. 22) is the only regional international treaty that enshrines 'the right to development', which arguably encompasses measures to address HIV/AIDS (see – Kuper, 2005, p.9). Uganda has also signed (in 2003) but not ratified the Protocol to the African Charter on the Rights of Women in Africa.

Certain human rights principles are relevant to HIV/AIDS, and can be found in these various treaties. These include the rights to non-discrimination, equal protection and equality before the law; to life; to the highest attainable standard of physical and mental health; of women and children; to liberty and security of person; to freedom of movement; to seek and enjoy asylum; to privacy; to freedom of opinion and expression and to freely receive and impart information; to freedom of association; to work; to marry and found a family; to equal access to education; to an adequate standard of living; to social security, assistance and welfare; to share in scientific advancement and its benefits; to participate in public and cultural life; and to be free from torture and cruel, inhuman or degrading treatment or punishment.¹⁰³

Of particular importance are the complaint and reporting mechanisms set up under some of the key international treaties that Uganda has ratified. The reporting mechanisms provide a channel through which NGOs and others can draw attention to HIV/AIDS-related legal and policy deficiencies generally in Uganda, while the complaints mechanisms can be used by individuals (or those acting on their behalf) to seek redress in international fora regarding the impact of these deficiencies on their own specific circumstances.¹⁰⁴

Further, various measures that directly address the issue of Uganda and/or HIV/AIDS (such as ‘General Comments’ on health rights) have been initiated by UN bodies charged with implementing a number of the relevant international treaties.¹⁰⁵

In any event, Uganda has become party to most of the major international human rights treaties – whether global or regional, general or specifically applicable to groups such as women and children – which between them cover a broad spectrum of economic, social, cultural, political and civil rights. There is, however, a big gap between the international treaties ratified and domestic law.¹⁰⁶

3. Domestic Law

In relation to domestic law, it is relevant that Uganda prior to 1995 was not a society that lacked such law. Some of the pre-1995 laws still in place that are pertinent to the HIV/AIDS epidemic (for example, laws regulating divorce, marriage, and succession, outlined below) date back to the beginning of the last century.

However, the cornerstone of Ugandan domestic law is now the 1995 Constitution, which was adopted after a national debate, involving a wide cross-section of Ugandans, which lasted for five years.¹⁰⁷ The pertinent provisions as regards HIV/AIDS include certain statements made in its Preamble, notably provision for the “fulfilment of the fundamental rights of all

¹⁰³ Kuper (2005), p.26.

¹⁰⁴ Kuper (2005), pp.31-33.

¹⁰⁵ These include the Committee on the Rights of the Child’s General Comment on HIV/AIDS and the Rights of the Child (2003), and their Concluding Observations on Uganda; the CEDAW General Recommendation No. 24 on Women and Health; the Committee on Economic, Social and Cultural Rights’ ‘General Comment 14’ on ‘the right to the highest attainable standard of health’, and the Human Rights Committees’ ‘Concluding Observations on Uganda’ (see Kuper, 2005, pp.17, 18, and 32 respectively).

¹⁰⁶ Uganda AIDS Commission (2004b), p.4, points out that although Uganda has ratified international human rights treaties it has little effective national legislation to implement these. See also Human Rights Watch (2003), p.3. For one approach to bridging this gap, see Helen Watchirs, ‘A Human Rights Approach to HIV/AIDS: Transforming International Obligations into National Laws’, *Australian Year Book of International Law*, 22 (2002), pp.77-112.

¹⁰⁷ See Khadiagala (2002), p.1677. The previous Constitution (1967) provided for human rights, but not explicitly rights for women, children, and the family.

Ugandans to social justice and economic development” (Objective XIV),¹⁰⁸ and for “basic medical services” to the population (Objective XX). Other relevant measures are those providing for equality under the law, and freedom from discrimination (Art. 21); protection against intentional deprivation of life except as regards the death penalty (Art. 22); the right to privacy of person, home and other property (Art. 27); the right to education (Art. 30); rights of the family, including that men and women over 18 are entitled to marry and to equal rights, and that laws will be enacted to protect the inheritance rights of widows and widowers regarding property and children (Art. 31); a duty of the state to take affirmative action in favour of marginalised groups (Art. 32);¹⁰⁹ rights of women to equality with men, and freedom from laws and customs which are against their dignity and welfare (Art. 33); and rights of children to, among other things, basic education, family life, protection from exploitation, and to special protection if orphaned or otherwise vulnerable (Art. 34).

The other particularly pertinent piece of post-1986 legislation is the 1997 Children Act, although some of its provisions are neither well drafted nor widely implemented, and it is currently under review.¹¹⁰ This Act provides for the welfare principles and children’s rights set out in the First Schedule to be the guiding principles in decisions made under the Act (S. 3); and provides that parents or other guardians have a duty to maintain the child, which duty gives the child certain rights including a right to medical attention (S. 5).

Additional legislation that has had a significant although indirect impact on the HIV/AIDS trajectory on Uganda is that which was enacted prior to the 1986 arrival of the NRM government, and which has been gradually undergoing revision to bring it in line with the rights laid out in the 1995 Constitution. This body of law includes:

- laws (some quite ancient) regulating marriages of various kinds, for example as regards Hindu, Muslim, customary or other marriages; permitting polygamy in relation to some marriages (such as Muslim marriages), and providing for monogamy for those making this choice;¹¹¹
- laws regulating divorce, again including specific laws for religious groups such as Hindus and Muslims. In addition to these, there is the 1904 Divorce Act, which provided that a man could divorce his wife on the sole grounds of her adultery, but a wife could only divorce her husband if she could prove adultery coupled with another matrimonial offence such as cruelty, desertion, bigamy or a change of religion. A ground-breaking case (Constitutional Petition No 2 of 2003, *FIDA and Five Others v The Attorney General*) recently declared this provision in violation of the 1995 Constitution;
- laws under the 1950 Penal Code, which made rape a felony punishable by death (Ss.123-125); made indecent assaults on a female a felony punishable by imprisonment with or without corporal punishment (S.128) (although corporal punishment is now prohibited, under a 2000 test case, which ruled it a violation of Constitutional provisions concerning torture and other inhuman or degrading

¹⁰⁸ This objective specifically includes ensuring that Ugandans have “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” (Objective XIV(b)).

¹⁰⁹ The groups specified are those marginalised ‘on the basis of gender, age, disability or any other reason created by history, tradition or custom’.

¹¹⁰ Information regarding the planned review was given in an interview with Paul Mwebesa, lawyer, Ugandan Law Reform Commission, 2005.

¹¹¹ Hindu Marriage and Divorce Act (1961); The Customary Marriage (Registration) Act (1973); The Marriage and Divorce of Mohammedans Act (1906), and The Marriage Act (1904).

treatment¹¹²); provided for the offence of ‘defilement’ (sexual intercourse with a girl under the age of 18 years), punishable by death (S.129) (it is worth noting that it is deemed immaterial whether or not the male is aware that the girl is below the statutory age of 18 years, and that defilement of males is not recognized under Ugandan law¹¹³); prohibited homosexuality, punishable by life imprisonment, as “carnal knowledge ...against the order of nature” (S.145); and made it an offence to deliberately infect another with an infectious disease (S.171);

- laws concerning inheritance, for example when people die intestate (the 1906 Succession Act), or which impose penalties for meddling with the property of the deceased (1933 Administrator General’s Act);¹¹⁴
- laws relating to health, such as the 1935 Public Health Act, and laws providing for treatment of those with venereal diseases (the 1977 Venereal Diseases Act).

Nonetheless, despite the fairly substantial body of law outlined above, it is worth noting that there seems to be quite a relaxed attitude in Uganda to some of the niceties of formal law, possibly reflecting a more flexible approach to its requirements, or simply limited resources for legislative reform and implementation, or indeed the central position of the NRM (as both the dominant political movement and the government). To cite a few examples:

- defilement remains a serious offence under Ugandan law, and many young men are imprisoned for this. However, as already indicated, there are thousands of marriages involving girls under the age of 18. While the legislation explicitly prohibits such marriages, it seems that in practice marriage is one way of informally legitimising defilement (and apparently young men are sometimes forced into marriage on this basis);
- the Children Act, as mentioned above, relies on rights and principles set out in its First Schedule to guide decisions made under the Act. However, the measures in this Schedule are subject to a reservation that arguably makes this crucial part of the Act so vague that it is unworkable, and that usually would be expressed through a different mechanism;¹¹⁵
- various laws relating to marriage still specify age limits (such as 16 for girls in both Hindu and customary marriages, while the Marriage Act 1904 provides for parental consent for marriages of those under 21), which are now in practice substituted by the Constitution for the age of 18. That is because the Constitution explicitly overrides “any other law or custom” inconsistent with Constitutional provisions (Art.2 (2)). This mechanism applies on the fairly frequent occasions when the older legislation has (to

¹¹² See Constitutional Reference No. 10 of 2000, *Kyamanywa Simon v Uganda*. Early in his regime, however, Museveni was on record in support of corporal punishment (Putzel, 2004, p.25).

¹¹³ The only provision akin to defilement of a boy is indecent assault of boys under 18 (S.147 of the Penal Code). The death penalty is apparently rarely imposed for this offence. Some writers argue that the death penalty has caused an increase in rape and defilement due to lack of police enforcement by officers who feel the penalty is too severe. Patten & Ward (1993), p.217 and n.46.

¹¹⁴ There is also a Land Act, which has been criticised for not allowing spousal co-ownership. See Human Rights Watch (Aug. 2003), p.5.

¹¹⁵ Among other things, the Schedule provides that children can exercise the rights set out in the Children Act and related international law ‘with appropriate modifications to suit the circumstances in Uganda, that are not specifically mentioned in this Act’. This is clearly difficult to interpret (which modifications and which circumstances?).

quote a Ugandan lawyer) not yet been “cleaned up” (i.e. made consistent with the Constitution).¹¹⁶

These factors indicate the complexity of law and law making in a country where many different legal norms and customs both compete and co-exist, and where resources are limited. Nonetheless, there is clearly a body of formal law in Uganda that is very relevant to HIV/AIDS. This formal law, some of which has a human rights component, has increasingly developed, particularly from 1995 onwards, and includes the revised Constitution, the Children Act, and various international treaties. At least in theory, the more recent law has enhanced the ability of the Ugandan state to regulate HIV/AIDS-related aspects of the life and conduct of its citizens.

Has Lack of Law, or Inadequate Law, Relevant to the Ugandan HIV/AIDS Strategy Become a Problem?

Thus although Uganda does not have legislation specifically concerning HIV/AIDS, it has a body of behaviour-related law that is extremely pertinent to individual and societal norms of conduct that affect the HIV/AIDS trajectory in the country. However, there remain problems in both the content of the law, and the fact that in Uganda law generally is not accessible and/or is prone to institutional problems.

As regards the impact of HIV/AIDS on women and children, a number of pertinent factors have already been outlined. Against the background of these factors there is a debate raging within Uganda as to the appropriate legal response, and initiatives are underway to formulate this. A significant step was taken in 1996 when an influential group of Ugandan lawyers prepared a study documenting deficiencies in their law regarding HIV/AIDS. The relevant law was conceptualised in the following three categories: product-related law (regarding safety of products such as blood); behaviour-related legislation (regarding legal and ethical intervention in the HIV/AIDS epidemic to promote social change); and capacity building and enhancement (law to enhance the capacity of individuals and government to address the epidemic).¹¹⁷ The law most pertinent to this paper is obviously the behaviour-related legislation.

When interviewed in 2005, one of the authors of this study confirmed that the majority of the legal deficiencies identified in 1996 have still not been addressed. They included, as regards law generally:

- the non-existence of law to govern particular problem areas, as well as the fact that in other situations existing laws had “long been written off” by the population “as grossly inadequate and/or outdated”;
- poor, or non-enforcement of and lack of respect for, law and human rights, even in cases where law exists (for example in maintenance for children and protection of widows and dependants of deceased persons);
- the general lack of legal information of the majority of Ugandans;¹¹⁸

¹¹⁶ Interview with Ugandan lawyer, 2005. Regarding ‘slow progress’ in bringing Ugandan law into line with the Constitution, see Khadiagala (2002), p.1680.

¹¹⁷ Esther Mayambala, Sam Tindifa, Regina Mutyaba, *Report of a Project to Review the Adequacy of the Existing Legal and Policy Framework in Uganda With Regard to the HIV/AIDS Epidemic*, Kampala: UNDP Kampala, 1996, pp.5-6.

¹¹⁸ See also Health Rights Action Group, *The Status of Human Rights Among People Living with HIV/AIDS in Uganda and Their Involvement in Initiatives Targeting Communities*, Kampala: Health Rights Action Group,

- the inaccessibility of formal courts of law by the majority of people, since the legal system is expensive and alien to them;
- the continuing conflict of laws, reflected especially in the relationship between customary and modern law, and modern law and Islamic law;
- the non-codification of the diverse customary laws of the various tribes in Uganda and of Islamic law, which makes it difficult to establish legal rules.¹¹⁹

As regards areas of law particularly relevant to women and children, the 1996 study made a number of pertinent observations, including:

- in relation to the Penal Code, the absence of provisions specifically proscribing domestic violence; inadequate protection of the property of orphans and of children generally against abuse and neglect by parents, guardians and those administering estates; lack of provision regarding the deliberate spreading of HIV/AIDS, and the fact that the definition of rape does not cover marital rape;
- in relation to family law, issues regarding marriage and divorce, such as problems concerning the rights and obligations of women in polygamous marriages; gender discriminatory divorce law, biased in favour of men; absence of legal recognition of cohabitation; absence of law regarding ownership of property acquired during marriage, and again, absence of laws regarding marital rape or domestic violence. As regards customary practices, the study cited absence of laws regulating practices such as female genital mutilation, early marriages, and widow inheritance, and, again, the non-codification of customary law;
- in relation to succession law, the study criticised, for example, inadequate provisions regarding protection of the deceased's dependents, and regarding surviving spouses' entitlement to the property of intestate deceased persons. It was also critical of the general lack of enforcement of succession laws and failings of law enforcement officers in this regard.¹²⁰

In addition to the above, the study highlighted certain problems specifically concerning the legal protection of inheritance by minors, and it devoted one section to discussing the legal situation of orphans, concluding that there was “need for government to create a supportive legal framework” to deal with issues created by the problem of orphans affected by HIV/AIDS and other vulnerable children. In discussing the situation of orphans, the study noted that although Ugandan policy is to provide home-based care for them within the extended family (and indeed residential care is seen as a ‘last resort’¹²¹): “the reality now is that the extended family is saturated with orphans and other survival problems” and “cannot

2004, p.viii, which summarises a study concluding that there were very low levels of knowledge and awareness of the meaning of ‘human rights’ among people living with HIV/AIDS.

¹¹⁹ Mayambala *et al.* (1996), pp.6-7. See also Takyiwaah Manuh, ‘The Women, Law and Development Movement in Africa and the Struggle for Customary Law Reform’, *Third World Legal Studies*, (1994-1995), pp.207-224, who argues (p.214) that customary law was created in response to colonial rule, in that “new ‘traditions’ and customs were invented to create new norms”. Further, she refers to other writers who argue that there was a strong element of gender and generational conflict in the creation and enforcement of customary law (p.216).

¹²⁰ Mayambala *et al.* (1996), pp.9-11.

¹²¹ See Ministry of Gender, Labour and Social Development (2004a), pp.5, 7, & 8. In a 2005 interview, Edward Mugyimba, Assistant Commissioner, Ministry of Gender, Labour and Social Development, confirmed that government policy is to try to avoid establishing orphanages, as this may institutionalise the problem.

effectively cope anymore”.¹²² The study also raised another significant issue: the increasing number of orphanages and children’s homes generally “which are not well regulated by the law”.¹²³

There were therefore many areas of law relevant to the HIV/AIDS pandemic in Uganda that were identified by the 1996 study as either lacking or inadequate. Other writers, too, have highlighted various difficulties in the current legal regime in Uganda, for example criticising the family law framework as “ambiguous, inconsistent, and excessively deferential to local religious leadership”.¹²⁴ The Parliamentary ‘Tool Kit’ notes that Uganda is lagging behind in establishment of national orphan strategies, and this point is also made by the Health Rights Action Group.¹²⁵

Subsequent to 1996, a number of laws have been drafted with the aim of remedying some of these legal deficiencies, but most still remain in draft and have not been adopted by Parliament. Indeed, a notable feature of Ugandan domestic law is the considerable length of time during which legislation can remain in draft form (see below).¹²⁶ As already mentioned, the Children Act was adopted in 1997, although it has some weaknesses and is to be reviewed by the Uganda Law Reform Commission.

Thus there is a problem in Uganda regarding lack of law, or inadequate law, relevant to the HIV/AIDS pandemic. It is of note that despite the many international treaties ratified, and the provisions of the 1995 Constitution, certain groups that are particularly affected by HIV/AIDS, such as women and children, lack the legal tools that could render them less vulnerable. This is either because existing laws are not well implemented, and/or there are gaps or inadequate provisions in the pertinent law. Nonetheless, the issue of legal reform is highly contested as regards some of the relevant issues, particularly in relation to long-standing cultural traditions such as polygamy and bride price, as will be outlined below. A key point to reiterate here is that some people within Uganda are themselves calling for these legal reforms, partly in response to the HIV/AIDS pandemic.

What is Being Done to Address Problems in Ugandan Law Relevant to HIV/AIDS?

The steps being taken to address these problems can be seen as an attempt to institutionalise through the mechanism of law the initial ‘emergency response’. They are also an attempt to address the inevitably unsatisfactory nature of a ‘project approach’ to tackling a major health

¹²² Mayambala *et al.* (1996), pp.42-46. The Parliament of Uganda, *The First Report of the Standing Committee on HIV/AIDS and Related Matters* (First Report): Kampala: the Parliament of Uganda, 27 Nov. 2003, p.22, points out that reliance on the extended family is linked to the lack of a welfare system. See also Government of Uganda *et al.* (2000), p.1; and Ministry of Gender, Labour and Social Development (2004a), pp.iii & 3.

¹²³ Mayambala *et al.* (1996), p.46. Another issue is the difficulty of keeping track of who and where the orphans are in Uganda (see e.g. Witter *et al.* (2004), pp.39-40).

¹²⁴ See Vanessa Von Struensee, *The Domestic Relations Bill in Uganda: Addressing Polygamy, Bride Price, Cohabitation, Marital Rape, and Female Genital Mutilation*, July 2004, paper downloaded from SSRN (Social Science Research Network), <http://ssrn.com/abstract=623501>, p.45.

¹²⁵ See *Tool Kit* (Parliamentary Standing Committee on HIV/AIDS (2004), p.24), and Caroline Migisha, *The Plight of Orphans and Vulnerable Children in the HIV/AIDS Era in Uganda*, Kampala: Health Rights Action Group, n.d., p.3.

¹²⁶ One notable example was the draft nature of the legislation establishing the Uganda AIDS Commission (Putzel, 2003, p.30).

crisis.¹²⁷ Thus, an HIV/AIDS policy based on an ethos of behaviour change, including notions of ethics and human rights, is to some extent finding expression in law. Moreover, a lack of legal reform is beginning to be identified as one factor in the stagnation of HIV/AIDS prevalence rates.

In charting the development of the relevant legal initiatives, it is useful to start with reference to the UNAIDS and UNICEF Framework Document drafted to implement the 2001 UN Declaration of Commitment on HIV/AIDS.¹²⁸ Among other things, this framework of action incorporates ten elements for a supportive legislative environment for tackling HIV/AIDS. These include:

- prohibiting discrimination based on actual or presumed HIV status;
- providing placement and guardianship for children lacking adequate adult care;
- ensuring women's rights to own property;
- protecting inheritance rights of widows and orphans;
- protecting children from abuse, neglect and sexual contact with adults;
- protecting children who live on the streets;
- developing policies that support and encourage family-based placements for children without adequate family care;
- establishing specific standards for alternative care of children without family support.

A number of the initiatives outlined below do in fact directly address some of these legislative aims. The most notable and comprehensive of these is also the most controversial: the 2003 Domestic Relations Bill (DRB), which was first mooted decades ago.¹²⁹

This Bill addresses a number of the legal inequities confronted by women in Uganda that have been identified as rendering them vulnerable to HIV/AIDS. Among other things, it provides that: after ten years of cohabitation a man and woman will generally be presumed to be married to each other (thereby enhancing the legal status, in particular, of the women in terms of property rights etc.) (S. 13); the minimum age of marriage is 18 (S. 18); each party to the marriage should freely consent to it (S.15); widow inheritance is prohibited (S. 16); and marriage gifts (bride price) should not be required (S. 20). The Bill nonetheless allows for Islamic, Hindu, Bahai and customary marriages to be governed by the rites and customs of the relevant group, although subject to limitations imposed by the 1995 Constitution and the DRB itself (S.29).

As regards 'Matrimonial Rights and Obligations', the DRB grants spouses "equal rights to consortium", while allowing a spouse to refuse sex if she/he fears that it is likely to cause physical or psychological injury or harm (S.60). Such harm would obviously include the risk of HIV infection. Further, the Bill makes adultery by either party to the marriage a criminal and/or civil offence, for which the wronged party can also claim compensation (S. 60), and

¹²⁷ Parkhurst (2002a), pp.318-319, describes the Uganda HIV/AIDS strategy as epitomising a project approach, which is not a particularly effective solution to health problems, being somewhat "disjointed" and "disorganised".

¹²⁸ See Kuper (2005), pp.20-21.

¹²⁹ Von Struensee (2003), p.3, estimates that it was mooted nearly 17 years prior to 2004, but others trace its roots back about 40 years, to the 'Kalema Commission' (see e.g., Human Rights Watch (Aug. 2003), p.3).

makes a number of provisions aiming to safeguard property rights (Ss. 64-72). It also contains measures regarding marriage breakdown, including allowing a petition for divorce (other than in Muslim marriages) to be based on the sole ground of irretrievable breakdown, while also expanding the grounds that constitute such breakdown (Ss. 73-74, 78, 81 and 89). Another innovation is that the DRB permits “non-monetary” contributions of a spouse to be taken into account in determining their share of the matrimonial home (S. 94).

The 2003 version of the DRB is in fact considerably shorter than some previous versions, as it has faced tremendous opposition, being repeatedly tabled in Parliament, shelved, and redrafted, over a number of years. This cycle was repeated again most recently in May 2005, when the Bill, tabled before Parliament as late as April 2005, was again withdrawn for reconsideration.¹³⁰ It has been criticised, on the one hand, by those who see it as undermining essential features of Ugandan family life, and who largely seem to favour the *status quo*; and on the other hand by those who feel it does not go far enough in changing current practice.¹³¹

Perhaps the most illuminating and stark example of this debate is found within the Ugandan Parliament itself, as evidenced by the ‘Report of the Committee on Legal and Parliamentary Affairs on the Domestic Relations Bill, 2003’. This brief report makes a number of observations about the DRB, and then proposes some sweeping amendments, starting with the name of the Bill (proposing that it be entitled ‘Marriage and Family Act’), and continuing from there. The observations made include the fact that: the Bill recognises various forms of marriage but then proceeds to provide some universal rules, (which is described as “an effort ...in futility”), and that the Bill recognises customary marriage, and yet outlaws marriage gifts which might be a requirement for such marriages. Criticisms are also made of the Bill’s proposals: legitimising cohabitation (arguing that such a concept is an attack on customary marriage, offending “moral values”); proscribing marital rape (arguing that in these cases the marriage has broken down and divorce should be the solution); regarding co-ownership of property, and widow inheritance (arguing that this term “is a deliberate coining to make this cultural form of remarriage derogatory”). The Report then proposes certain amendments, which seek in effect to remove most of the key innovative provisions from the 2003 DRB.

At about the same time as the above Report was being drafted and circulated, the Parliamentary Standing Committee on HIV/AIDS published its ‘Tool Kit’, which takes quite a different stance. Without overtly supporting the DRB, this document makes plain that it considers, for example, gender inequality a significant factor in the spread of HIV/AIDS, and

¹³⁰ One lawyer (name withheld) interviewed in Kampala in 2005 felt the latest withdrawal of the DRB was possibly due to fierce opposition within the Muslim community to the Bill’s proposed restrictions on polygamy, and also to political considerations, since Museveni was positioning himself to run for a third term and may have felt the DRB would count against him.

¹³¹ Von Struensee criticises the Bill for a number of weaknesses, including that: despite imposing limitations, it continues to permit polygamy, which perpetuates women’s subordinate status (pp.14-35, and 93-97); it relinquishes authority over Muslim marriages, thereby allowing these to be governed by gender-biased rules (p.46); its prohibition on bride price is ambiguous (pp.98-104); and it offers inadequate protection against marital rape (pp.127-150). Taking an opposing view, another writer expresses doubt that attempts to regulate deeply-ingrained cultural practices are realistic, arguing the unprotected sex is “the real problem” (Kenneth J. Bartschi, ‘Legislative Responses to HIV/AIDS in Africa’, *Connecticut Journal of International Law*, 11:1 (1995), pp.186-187). See also Brooke Grundfest Schoepf, ‘Uganda: Lessons for AIDS Control in Africa’, *Review of African Political Economy*, 30:98 (Dec. 2003), pp.553-572, who describes as a human rights violation the pressure to stay within steady relationships as a means of avoiding HIV-infection (p.568).

contains statements such as “faith sanctioned polygamy and prohibiting the use of condoms are vivid examples of religious impediments” to the prevention of HIV/AIDS.¹³²

Against the backdrop of these debates there also remain in draft a number of other Bills aiming to address further behaviour-related HIV/AIDS risk factors. These include the 2004 Penal Code Amendment Bill, which, among other things, addresses the issue of defilement and proposes that the sentence for this becomes life imprisonment (although the death penalty remains for “aggravated defilement”, such as where the person “defiled” is under 14), and removes the gender bias of the previous law so that women, too, can be found guilty of committing this offence (S. 129). Other pertinent draft Bills include the Sexual Offences Bill (which in April 2005 was not yet published as such, as it was awaiting Cabinet approval). This Bill would make marital rape an offence; change the maximum penalty for rape from death to life imprisonment; and also, interestingly, remove cases concerning impregnation and elopement of girls under 18 from the jurisdiction of the local councils as “these trials were in most cases mishandled”. There is also a lobby in Uganda for lowering the age of defilement from 18 to 16,¹³³ although this is controversial and is not in the draft Bill. The Sexual Offences Bill also proposes amending the Venereal Diseases Act by adding AIDS as a sexually transmitted disease.

A number of these proposed legal reforms are in line with recommendations made in the 1996 study on the adequacy of HIV/AIDS-related Ugandan law. This study also made many other recommendations, including that: the possibility of an HIV/AIDS law covering all aspects of relevant law be explored; customary laws should be codified and all laws harmonised; research should be done on developing a framework for the protection of orphans;¹³⁴ and that there should be provision of general legal education and improved access to courts. It also made various specific recommendations dealing with family law, succession, orphans, and customary practices.¹³⁵

While these attempts at legislative reform are taking place, a group of Ugandan lawyers, tired of the slow pace of change, have begun initiating a series of test cases concerning some of the pertinent issues. They have already won a major case (already mentioned) that enables women, like men, to now petition for divorce on the sole grounds of their spouse’s adultery.¹³⁶ These lawyers were, in 2005, on the brink of filing further Constitutional Court cases, including cases challenging as unconstitutional certain provisions in the current law on succession, and adultery.¹³⁷

Further relevant initiatives are also underway. For example, the Uganda Association of Women Lawyers (FIDA) has for many years been taking HIV/AIDS-related cases, generally

¹³² *Tool Kit* (Parliamentary Standing Committee on HIV/AIDS (2004), Chapter 6, pp.224-241, and p.248 respectively. See also Parliament of Uganda (2003).

¹³³ Information given in 2004 by, among others, Margaret Sekaggya, Chairperson of the Uganda Human Rights Commission.

¹³⁴ See also Wakhweya, Kateregga, *et al.* (2002), p.155.

¹³⁵ Mayambala *et al.* (1996), pp.54-81.

¹³⁶ *FIDA and Five Others v The Attorney General*. This case also had the result that wives could claim damages from women committing adultery with their husbands (a remedy previously only available to husbands), and that in principle husbands may be entitled to claim alimony from their ex-wives.

¹³⁷ 2005 interview with Regina Mutyaba, lawyer. As regards succession, the provisions complained about include the fact that a widow is generally granted 15% of the joint property, while a widower is entitled to 100%. Regarding adultery, the contentious provisions include penalties in place to punish married women for having sexual relationships with unmarried men, while married men face no such penalties for the equivalent.

on behalf of women. The organisation, founded in 1974, aims to increase access to justice and legal protection of vulnerable groups such as women and children through court representation and legal advice. When interviewed in 2004, one of the FIDA lawyers confirmed that most of their cases are resolved through alternative dispute resolution mechanisms, using court procedures as a last resort, due to their expense and delays. She stated that their casework frequently relied on the 1995 Constitution, and international treaties such as that prohibiting discrimination against women, although FIDA lawyers apparently find the current legal regime limited, and have forwarded recommendations regarding this to the Law Reform Commission.¹³⁸

In recent years FIDA, with Plan International, has specifically initiated projects for people living with HIV/AIDS, providing legal aid in the form of will-making assistance; following up cases of violations of the rights of people with HIV/AIDS; and creating legal awareness in the target population (including by drawing attention to the importance of birth registration, as most births in Uganda are not formally registered¹³⁹). These projects are limited to certain geographical areas, with the most recent one being launched in May 2005.¹⁴⁰

The Uganda Human Rights Commission has also been undertaking work on HIV/AIDS in recent years. According to their Sixth Annual Report, the Commission's role in this regard was to "ensure the right to health, as in all human rights, is respected, protected and fulfilled".¹⁴¹ This Report stated that people affected by HIV/AIDS in Uganda were often left vulnerable and denied equal access to fundamental rights and freedoms, "in spite of pillars of equality and non-discrimination . . . that are guaranteed by the Constitution and international law".¹⁴² It specifically called for amendment to Article 21 of the Constitution on discrimination, "to provide health status as a ground protected from discrimination".¹⁴³

Another agency of interest here is the Uganda Law Reform Commission, which was actively involved in work on the DRB. When visited in 2005, the Commission was working on a 'concept paper' concerning 'community level reform'. This interesting project deals with legal education, aiming to sensitise the public regarding legal issues, moving away from a focus on Kampala to "interact with the grass roots to get a dialogue with them over legal issues, and involve them in consultations".¹⁴⁴ This initiative seems extremely timely in addressing the urban/rural divide in knowledge and attitudes. However, it is anticipated that 'resource issues' are likely to prove a hindrance to implementing this project.

Finally, it is worth mentioning that while there are strong initiatives to enhance the legal rights of women and children generally, as well as people living with or affected by HIV/AIDS, some of those interviewed in 2005 referred to certain opposing views. One mentioned a "new debate" arising from the fact that some Ugandans are apparently beginning to feel that living with HIV/AIDS now entails a number of advantages (for example in terms

¹³⁸ Interview with Annette Ttendo, Head of Advocacy Work, 2004.

¹³⁹ According to Wakhweya, Kateregga, *et al.* (2002), p.4, only 4% of births were registered in 2000, and there is a lack of official records including those regarding deaths (pp.11 and 181).

¹⁴⁰ Another newer (established in 2001) and smaller NGO based in Kampala, the Health Rights Action Group, is now specifically working on promoting access to health care and treatment as a human right for all people living with HIV/AIDS and other diseases.

¹⁴¹ Uganda Human Rights Commission, *6th Annual Report*, Kampala: Uganda Human Rights Commission, 2003, p.145.

¹⁴² Uganda Human Rights Commission (2003), p.148.

¹⁴³ Uganda Human Rights Commission (2003), p.155.

¹⁴⁴ Interview with Law Reform Commission lawyer Paul Mwebesa.

of treatment and general care) that make it look like a privileged status. This therefore gives rise to the challenge of providing a good service without making HIV/AIDS look appealing.¹⁴⁵ Another interviewee referred to the fact that there was beginning to be some discussion about making HIV/AIDS testing less voluntary (taking the ‘V’ out of ‘VCT’ (voluntary testing and counselling)) – since scientific advances and other developments meant that a diagnosis of HIV was no longer a death sentence.¹⁴⁶

It is evident from the above that, far from being a non-issue, HIV/AIDS-related law in Uganda is the subject of considerable attention in some sectors. The converging and conflicting views on this law are perfectly encapsulated in the struggle over the DRB. Despite this attention, it is clear that there are as yet major obstacles to fulfilling a number of the key legislative elements identified by the UNAIDS and UNICEF Framework Document mentioned above. For example, the lengthy stalemate in enacting the DRB means that obstacles remain to ensuring women’s rights to own property, and to protecting the inheritance rights of widows (and consequently their children). In other areas, such as the rights of children generally, while law may be in place ‘on paper’, either the law is to some extent inadequate (for example certain provisions in the 1997 Children Act), or not well resourced or implemented.¹⁴⁷ Much therefore remains to be done in this sphere.

Conclusion and Recommendations

In writing this paper I had two aims. The main and most obvious one was to examine the role of law, particularly human rights law, as a tool in helping to mitigate the impact of HIV/AIDS, with reference to the experience in Uganda as a particularly pertinent ‘case study’. The other, underlying, aim was to explore the significance of law as part of a strategy to address the formation or prevention of crisis states, and indeed other major development challenges. The paper sought to fulfil these two aims by examining the idea that there are situations where a major development challenge, such as HIV/AIDS, has been successfully addressed without much, or any, recourse to formal law, and especially human rights law. Uganda’s strategy in addressing its HIV/AIDS pandemic is generally assumed to be just such a situation.

In testing this assumption, it has been shown here that: 1) Uganda’s HIV/AIDS strategy, while impressive in some respects, has in fact not been an unequivocal success, and indeed may be currently backsliding, since the most recent (2005) prevalence rate of 7 percent of the adult population is higher than the 6-6.5 percent rate recorded in the previous measurements;¹⁴⁸ 2) although formal law was not a major part of Uganda’s HIV/AIDS strategy particularly prior to 1995, the unique circumstances in the country in the early years of the NRM government meant, in effect, that policy, including HIV/AIDS policy, arguably had a ‘quasi-legal’ nature; and 3) in recent years, particularly post-1995, there has been a formal legal underpinning (which includes human rights law) to aspects of Uganda’s HIV/AIDS strategy, as represented chiefly by the revised Constitution. Further, segments of

¹⁴⁵ Interview with Kindyomunda Rosemary Mwesigwa, Uganda AIDS Commission.

¹⁴⁶ Interview with NGO representative (name withheld). For discussion of this issue, see e.g. Putzel (2003), pp.39-40, and Kuper (2004), pp.22-23.

¹⁴⁷ Some of those interviewed in Kampala in 2005 pointed out that the ‘Family and Children’ courts supposedly established under this Act are either non-existent or unfair. Further, see local study in Rakai, highlighting difficulties regarding resources for and provision of trained probation and social welfare officers (Witter *et al.* (2004)). See also Wakhweya, Kateregga, *et al.* (2002), p.15.

¹⁴⁸ Estimate given at the 3rd HIV/AIDS Forum (Uganda AIDS Commission, Office of the President (2005), p.9

the Ugandan population are themselves actively promoting legal reform as a missing link in this context.

How do these conclusions relate to the question of law as part of a strategy for addressing crisis states and other major development challenges? The answer is: indirectly. In this study, human rights law is taken, in a sense, as a symbol representing generic domestic and international law, and HIV/AIDS is taken as a symbol representing a major development challenge whose trajectory is likely to contribute to either mitigating or aggravating crisis. Transposing the wording used in the Introduction, the hypothesis being tested becomes, therefore: if a major pillar of current national and international law (human rights law) has a role to play in addressing a major development challenge particularly for many crisis states – even in a situation, such as Uganda, where it is assumed to be irrelevant – then substantive law should at least be considered as one element in strategies to address such challenges. It should not be left out of the equation.

Further, attention should be paid to the content of the law itself, and not simply to institutional matters such as corruption or lack of resources (which have more to do with the ‘rule of law’). As evidenced in the Uganda study, content matters. Regardless of how efficient the legal institutions may be, if the substantive law itself does not make the necessary provision – for example for inheritance rights of women and children – efficient institutions in themselves will not be able to deliver. The converse also applies. An impressive body of law ‘on the books’ will have little impact in practice if the legal institutions are incapable of implementing it. This was also illustrated in the Uganda study (particularly with regard to the 1995 Constitution).

As to the role of law in tackling the HIV/AIDS pandemic, this study has found that law, in one form or another including human rights law, has been woven into the fabric of Uganda’s HIV/AIDS strategy from quite an early stage, and is now an increasingly visible element of this. However, the relevant law is complex and controversial, involving concepts of ‘human rights’ and of ‘customary law’, particularly as regards regulating behaviour that can increase or decrease the risk of HIV/AIDS. These concepts are open to misunderstanding and, to some extent, to differing interpretations.¹⁴⁹ Thus, while some see ‘customary law’ as a defined and established body of rules, it has been criticised by others for being an arbitrary and male-dominated invention.¹⁵⁰ Further, the terms ‘human rights’ and ‘human rights law’ are often used loosely and interchangeably, and both can be used instrumentally by those with opposing aims.¹⁵¹

Thus, the legal regulation of HIV/AIDS in Uganda inhabits sensitive territory where customary and ‘modern’ law, the old and the new, clash – as evident, for example, in debates concerning the DRB and other legal reforms. This clash is also evident in the pronouncements of key political figures such as Janet Museveni, the influential First Lady, who stated during the Third HIV/AIDS Partnership Forum in 2004 that Ugandans “should deliberately hang on to our roots and only borrow global values that are like our own”.¹⁵² This statement perfectly

¹⁴⁹ Kuper (2005), p.5. A lawyer interviewed in Kampala in 2005 (Caroline Migisha) gave the example of one novel interpretation of human rights entitlements, when she described a session with school-children in which the boys demanded their right to small condoms.

¹⁵⁰ See Mayambala *et al.* (1996), pp.6-7; and Manuh (1994-1995).

¹⁵¹ See Kuper (2005), p.5.

¹⁵² Uganda AIDS Commission, Office of the President (2005), p.8.

sums up the tensions inherent as regards HIV/AIDS-related legal reform in Uganda, and the unfolding dialogue on this issue.

One international lawyer sees this type of dialogue as representing what he calls the “paradox of normative universality”. He argues that “normative universality in human rights should neither be taken for granted, nor abandoned in the face of claims of ... cultural relativity”, and suggests that proponents of change must put forward, for example in introducing human rights principles, a proposed alternative perspective “consistent with the *internal* criteria of legitimacy within the culture, and appreciated as relevant to their needs and expectations”. He therefore supports what he terms an “internal dialogue” within the culture itself, not one imposed by outsiders.¹⁵³ Arguably this ‘internal dialogue’ is precisely what is taking place as regards HIV/AIDS-related law – and particularly human rights law – in contemporary Uganda.

A few general recommendations can now be made:

This paper has highlighted various ways in which women and children in Uganda are particularly vulnerable to HIV/AIDS. The DRB is one initiative that aims to address many of these issues particularly regarding women, and, as such, its key provisions for enhancing their status should become part of Ugandan law. A lawyer interviewed in Kampala in 2005 argued that it was time that donors put financial pressure on the Ugandan government to finally adopt this legislation. This may indeed be one strategy to resolve the deadlock that could otherwise (given the lengthy delays in legal implementation) drag on for many more years.

Another issue that clearly needs to be addressed is the situation in which thousands of girls under 18, and even under 14, are getting married illegally, and where large numbers of males are being imprisoned for defilement even when, to use the terminology employed in one study, the defilement is “loved” rather than “forced”.¹⁵⁴ This situation renders children and young people vulnerable to HIV/AIDS in a number of ways, and a concerted effort is called for to find appropriate responses. Law reform should be part of this response, for example as regards improving procedures for marriage registration; decriminalising defilement and hearing such cases in family courts, and, possibly, reducing the applicable age for both marriage and defilement from 18 to 16 in clearly-defined circumstances (although this is controversial). However, this strategy would also have to include a much wider agenda tackling poverty, which is a major contributory factor as regards early marriage.

Last but not least, another huge issue is the problem of orphans and other vulnerable children. Despite many policy documents and initiatives, the situation of large numbers of orphans in Uganda remains dire. Among contributory factors here are problems such as: lack of birth registration and/or registration as orphans; property-grabbing and ensuing homelessness; overstretched extended family networks, and children’s homes that are not adequately regulated or resourced. Many of these problems could and should be addressed either by amendments to current law and/or improvements in its implementation.

The need for law reform regarding children orphaned or made vulnerable by HIV/AIDS has been recognised, among others, by the World Bank, which organised a conference on this

¹⁵³ Abdullah An-Na’Im, ‘Cultural Transformation and Normative Consensus on the Best Interests of the Child’, in Philip Alston (ed.), *The Best Interests of the Child*, Oxford: Clarendon Press, 1994, pp.64-65, 68 and 79. See also An-Na’Im (1999), p.59.

¹⁵⁴ Witter *et al.* (2004), p.26.

topic as recently as May 2005, for which a report was prepared summarising the main pertinent international law and policy principles, and including reference to Uganda as one of three countries studied.¹⁵⁵ This report stressed, among other things, that “a sound legislative framework provides an indispensable basis for coherent and progressive social action”, and that the 1989 CRC is a particularly important legal instrument in this context.¹⁵⁶

UNICEF has also recently published a ‘Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV/AIDS’. This document makes two particularly important points: 1) that “(c)hildren, too, can be powerful agents of change, a role that enhances their confidence and self-esteem as they become partners in the fight against HIV/AIDS”; and 2) that interventions in this context should be:

directed to all vulnerable children and the communities in which they reside, and integrated into other programmes to promote child welfare and reduce poverty. Targeting children living with HIV or AIDS or orphaned as a result of it will only serve to exacerbate the stigma and discrimination against them.

The Framework then sets out five key strategies, including one recommending “improved policy and legislation”.¹⁵⁷

As regards legal and related problems faced by orphans and other vulnerable children in Uganda, one possible strategy would be the provision of an improved legal network that could provide children with appropriate impartial advice - although of course this has resource implications, and again has to be part of a wider strategy addressing key issues such as poverty reduction. As things stand, organisations like FIDA do provide some advice to children, but for example their 2003 Annual Report showed that in that year only 5 percent of their clients were children (although the report stresses that a high proportion of cases brought by their women clients relates to children).¹⁵⁸ This highlights the fact that it is difficult for children to independently access legal advice due to the largely rural population base, and lack of knowledge about and availability of accessible advice even in urban areas. Further, children in Uganda can apparently only participate in formal court cases through an adult – and some court proceedings require the presence of probation or social welfare officers, and these are in scarce supply.

Another organisation, the Health Rights Action Group, does specifically include a programme on orphans and vulnerable children in its work plan, with the mandate of assessing the impact on them of HIV/AIDS. Expected outcomes of this programme include identifying the human rights abuses experienced by these children, educating communities on how best to address this issue, and advocating for a review of the relevant legal and policy framework.¹⁵⁹ Clearly, however, this relatively small NGO will need to work with others, such as FIDA and,

¹⁵⁵ See Annemarie Meisling & Rudolph V. Van Puymbroeck, *Legal Protection of Children Orphaned or Made Vulnerable by HIV/AIDS: International and Selected Domestic Law*, discussion draft, Washington: World Bank, Apr. 30, 2005 (<http://www4.worldbank.org/legal/legkm/docs/Orphans043005.pdf>, accessed on 7 June 2005).

¹⁵⁶ Meisling & Van Puymbroeck (2005), pp.14-15.

¹⁵⁷ UNICEF, *The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV/AIDS*, New York: UNICEF, July 2004.

¹⁵⁸ The Uganda Association of Women Lawyers FIDA-Uganda, *Annual Report 2003*, Kampala: Uganda Association of Women Lawyers FIDA-Uganda, 2003, n.d., p.5.

¹⁵⁹ Health Rights Action Group, *Annual Report 2004*, Kampala: Mulyanga Enterprises Limited, 2004, p. 4. The Report notes here that in carrying out this programme, there is ‘difficulty in accessing the most poverty hit corners of the country in time.’

particularly, the Ugandan government, in finding solutions to this problem.¹⁶⁰ Once again, a ‘project approach’ should be avoided.

An enhanced network providing legal and related advice specifically for children could possibly be based, with additional funding, in an established organisation such as FIDA and/or channelled through other existing services. It could, among other things, provide useful information on the legal problems vulnerable children face and, if necessary, assist them in taking cases.¹⁶¹ Any such network would, however, have to manage a delicate balancing act in ensuring that a ‘child-rights’ approach did not prove counter-productive, for example in discouraging extended families from accepting orphan children. According to a lawyer interviewed in 2005, many Ugandans are wary that providing children with increased access to legal rights could make them “big-headed”.¹⁶² A focus on alternative dispute resolution wherever possible, and on instances of serious abuse, for example in relation to property-grabbing or sexual conduct, might make best use of a legal approach and limited resources here, and be less likely to provoke a backlash.

In any event, there is one clear advantage to prioritising, as regards legal reform, a campaign to address the plight of orphans and other vulnerable children. That is, such a campaign seems to some extent less controversial than initiatives to address deeply ingrained and contested cultural norms such as those relating to early marriage and gender, and hence might make more rapid progress. While the more controversial initiatives should remain firmly on the agenda for change, they may well undergo many more years of stalemate – and in the meantime progress could probably be made as regards orphans and vulnerable children, an issue which impacts profoundly on the lives of many Ugandans.

In conclusion, two final points can be made. First, it is vital to bear in mind that each country is different as regards the appropriate HIV/AIDS strategy.¹⁶³ What works in one country may not work in another for a variety of reasons, including lack of resources. When it comes to HIV/AIDS there is no simple ‘one size fits all’ solution. Second, Uganda is seen in many quarters as a ‘success story’ as regards HIV/AIDS, and it is therefore studied extensively for lessons to learn that can be applied in other countries. Therefore, it is essential that the lessons learned are the right ones, based on a careful analysis of exactly how the strategy seems to have operated. This paper has shown that it is not accurate to portray the Uganda HIV/AIDS strategy as ‘no-law’ and policy-based. Law in one form or another is an increasingly significant feature of Uganda’s response to the HIV/AIDS pandemic.

¹⁶⁰ There are also other organisations that provide HIV/AIDS-related advice and information to children in Uganda, in particular the well-known NGO ‘Straight Talk’. As well as publishing newspapers for different constituencies, this organisation runs radio programmes, and workshops in schools. However, Straight Talk is not primarily a source of legal information.

¹⁶¹ For example cases could, where appropriate, be taken through new complaints procedures shortly to be operational under the African Charter on the Rights and Welfare of the Child, or through the African Court on Human and Peoples’ Rights. See Kuper (2005), p.33.

¹⁶² Interview with Caroline Migisha.

¹⁶³ See Kuper (2005), p.36.

Abbreviations

CEDAW = Convention on the Elimination of All Forms of Discrimination against Women

CRC = Convention on the Rights of the Child

DRB = Domestic Relations Bill

FIDA = Uganda Association of Women Lawyers

ICCPR = 1966 International Covenant on Civil and Political Rights

ICESCR = 1966 International Covenant on Economic, Social and Cultural

MACA = Multisectoral Approach to the Control of AIDS

NRM = National Resistance Movement

NSF = National Strategic Framework for HIV/AIDS

PEAP = Poverty Eradication Action Plan

STDs = sexually transmitted diseases

TASO = The AIDS Support Organisation

UNPAC = Uganda National Programme of Action for Children

UNGASS = UN General Assembly Special Session on HIV/AIDS

VCT = voluntary testing and counselling

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The aim of the Crisis States Programme (CSP) at DESTIN's Development Research Centre is to provide new understanding of the causes of crisis and breakdown in the developing world and the processes of avoiding or overcoming them. We want to know why some political systems and communities, in what can be called the "fragile states" found in many of the poor and middle income countries, have broken down even to the point of violent conflict while others have not. Our work asks whether processes of globalisation have precipitated or helped to avoid crisis and social breakdown.

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- We will examine the effects of international interventions promoting democratic reform, human rights and market competition on the 'conflict management capacity' and production and distributional systems of existing polities.
- We will analyse how communities have responded to crisis, and the incentives and moral frameworks that have led either toward violent or non-violent outcomes.
- We will examine what kinds of formal and informal institutional arrangements poor communities have constructed to deal with economic survival and local order.



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