UNIVERSITY *of the*
WESTERN CAPE

ACCESS TO HIV TREATMENT FOR REFUGEES: CASE STUDY OF SOUTH AFRICA AND UGANDA

Research Paper Submitted in partial fulfilment of the requirements

for LLM degree

By

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19 December 2015

DECLARATION

I, Jessica Tshiosha, declare that "**Access to HIV Treatment for Refugees: Case Study of South Africa and Uganda"** is my work and has never been presented to any other university or institution. Where other people's works have been used, references have been provided, and in some cases, quotations made. In this regard, I declare this work as originally mine. It is hereby presented in partial fulfilment of the requirements for the award for LLM Degree.

Signed…….

Date……..

Supervisor: ……..

Signature…….

Date……..

DEDICATION

This work is dedicated to the memory of my behold father Tshiosha Kamunga Leonard; your early departure was a passage for me to another world. Even in your silence, you inspired me.

This work is also for my lovely mother Keta Marie-Jacqueline who raised me up to reach for the skies and lovely sisters Rosine Tshiosha, Noella Tshiosha, Mirabelle Tshiosha, Vanessa Tshiosha, Patricia Tshiosha, Wanida Tshiosha, Gladhys Tshiosha, Deborah Tshiosha and my lovely brothers Delphin Tshiosha, Toto Tshiosha, Filstony Tshiosha, Tresor Tshiosha, Mike Tshiosha. Without you, I cannot live.

ACKNOWLEDGEMENTS

First I would like to thank the Father of fatherless for providing through my studies. In addition I would like to thank the following people for their valuable support without which this work would not have been successful. First, I am highly beholden to my supervisor Prof Durojaye for his immense knowledge, my mentor and a source of inspiration; for his diligent and valuable comments. In fact if I were to create my own dictionary the name Papa Nebesse would be next to the words supportive. I am also grateful to my friends and my entire family back home for their love and support. Lastly but not least, I thank Soraya Beukes and all those who provided their valuable time and input in various ways over the period that preceded the completion of this work.

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List of Acronyms

ACHPR	African Charter on Human & Peoples' Rights.
ACPHR	The African Commission on Human and Peoples' Rights.
ACRWC	African Charter on the Rights and Welfare of the Child
AIDS	Acquired Immune Deficiency Syndrome
ARVs	Anti-Retrovirals
AU	African Union
CESCR	Committee on Economic, Social and Cultural Rights
CRC	Convention on the Rights of the Child
CERD	Committee on the Elimination of Racial Discrimination.
HIV	Human Immuno-deficiency Virus
ICERD	International Covention on the Elimination of All Forms of Racial Discrimination.
ICESCR	International Covenant on Economic, Social and Cultural Rights.
TAC	Treatment Action Campaign
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDHR	Universal Declaration of Human Rights.
UNHCR	United Nations High Commissioner for Refugees

CHAPTER 1

INTRODUCTION

1.1 Background

South Africa has the largest number of people living with HIV in the world.[1] In the late 1980[s], Uganda was widely viewed as the worst HIV/AIDS affected country in the world. It was also very poor and only just beginning to recover from decades of political upheaval. It had a relatively large population of over 20 million, divided into numerous different language groups. It had extremely limited public health and education systems, high levels of illiteracy and low life expectancy.[2] However apart from the decimation of the most productive segments of the population, the HIV/AIDS pandemic continues to undermine the institutions and human capital development strategies on which future health, security and progress depend.[3]

Internationally the link between human rights and HIV is well recognised and persons who experience inequality, prejudice, marginalisation and limitations on their social, economic and cultural rights are at a greater risk of HIV exposure.[4] People affected by HIV confront unique barriers to health care access and treatment including concerns regarding confidentiality, denial of access to asylum procedures, fears regarding refoulement and restrictions.[5] In most cases host governments do not incorporate refugees into their HIV/AIDS programs. Resource constraints limit the ability of the United Nations High Commissioner for Refugees (UNHCR) and its

[1]'New HIV Report Finds Big Drop in New HIV Infections in South Africa' available at *http://www.unaids.org/en/resources/presscentre/featurestories/2014/january/20140117southafrica/* [accessed on 1 July 2014].

[2]Allen T & Healed S 'HIV/AIDS Policy in Africa: What has Worked in Uganda and What has Failed in Botswana?'(2004) 12 *Journal of International Development* 1142.

[3]Tshoose C (2013) 409.

[4]Gerntholtz et al 'Disability Rights and HIV/AIDS in Eastern and Southern Africa A review of International, Regional and National Commitments on Disability Rights in the Context of HIV/ AIDS in Eastern and Southern Africa Final Report' (2010) 3 available at *http://www.heard.org.za/downloads/disability-rights-and-hiv-aids-in-eastern-and-southern-africa.pdf*[accessed on 29 June 2014].

[5]'Access to Antiretroviral Therapy in Africa Status Report on Progress Towards the 2015 Targets UNAIDS' (2013) 6 available at *http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/20131219_AccessARTAfricaStatusReportProgresstowards2015Targets_en.pdf* [accessed on 29 June 2014].

partner organisations to provide the same level of HIV/AIDS services enjoyed by host nationals.[6] Refugees often travel a considerable distance to access services, expending considerable time and money.[7] Even where drugs were free and health services available, patients struggled to access them due to obstacles, such as, high fuel and transport costs. Under such circumstances patients cannot afford all the basic necessities and are forced to migrate, with deleterious consequences for treatment.[8] Therefore where these are experienced by refugees and asylum seekers when attempting to access healthcare and other services, protective policies have not transformed into protective practices.[9] This in turn may raise their exposure to HIV infection and may undermine their facility to access available HIV related services.

Finally, integrated refugee and host health services are reported in a few African countries such as, South Africa and Uganda. There are widespread reports that health care personnel refuse refugees access to health services to which they are entitled.[10] The success of these integrated health services remains doubtful because refugees consistently face discrimination and xenophobic attitudes from these health services. The presence of illegal refugees makes the situation worse as these refugees may not go to public hospital to attain health care.

To summarise, this research recommends that the human rights obligations vis-à-vis responses to access to health care for refugees requires consideration. The conclusions and overall position of this research is that in relation to access to health care refugees are exposed to HIV and are not accessing the prevention, testing and care in the lack of a legal framework to pledge their protection and address their specific requirements in this area of consideration.

This study analyses key international, regional and national instruments concerning refugees and identifies a limitation of the extent to which the African human rights system has added to the

[6] 'Report on Refugees and Internally Displaced Persons' (2006) 2 available at *http://www.state.gov/documents/organization/63694.pdf* [accessed on 29 June 2014].
[7] Laughlin et al 'Testing experiences of HIV Positive Refugees in Nakivale Refugee Settlement in Uganda: Informing Interventions to Encourage Priority Shifting' (2013) 7 *Conflict and Health* 6.
[8] Veenstra et al Unplanned Antiretroviral Treatment Interruptions in Southern Africa: How Should We be Managing These? (2010) 6 *Globalisation and Health* 2.
[9] Vearey J 'Migration, Access to ART and Survivalist Livelihood Strategies in Johannesburg' (2008) 7. *African Journal of AIDS Research* 365.
[10] 'National Consortium for Refugees Affairs Summary of Key Findings: Refugee Protection in South Africa' (2006) 7 available at *http://www.cormsa.org.za/wp-content/uploads/2008/06/ncra06.pdf*. [accessed on June 29 2014].

effective protection of the rights to access to health care in the context of HIV, given the complex nature of the concept refugee.

1.2 Problem Statement

The access to HIV treatment by refugees remains a challenge for both the South African and the Ugandan governments. The ESCR and other human rights instruments at international level are provided for and guaranteed in South Africa and Uganda[11] but these are challenges: depraved governance; maladministration of public finances by political authorities at the expense of the majority; absence or weakness of the institutions or organs of implementation; and ignorance of refugees about their rights even if they are tremendously violated by government. In the light of the above problems and based on the human rights obligations of the governments of South Africa and Uganda there is a need for these countries to adopt appropriate steps and measures in order to facilitate access to HIV treatment for refugees in their countries

1.3 Literature Review

There is a dearth of literature on access to essential treatment in Uganda from a human rights perspective. Hughes argues that, the condition of HIV/AIDS and human rights in Southern Africa address the limitations on access to HIV/AIDS drugs, and identify the discordance policy, legislation and practice.[12] Sisulu argues that the manifestation of xenophobia in South Africa by nationals can be attributed to inexperience of the population in hosting refugees and other non-nationals particularly those from other African countries. According to her, the South African society has not been sufficiently educated on the issue of refugees, the causes of refugee movement, and government responsibilities towards refugees. Sisulu concludes that xenophobia bars access to public health.[13] Peberdy and Majodina argue that unemployment and the fact that refugees and asylum seekers may find themselves in low income employment may affect their ability to access health services.[14] Mann has argued that most public health programmes and

[11]Articles 34-48 of the DRC Constitution of 18 February 2006.
[12]Hughes K Human Rights Protected: Nine Southern African Country Reports on HIV/AIDS and the Law LLM Thesis University of Pretoria (2007) 22.
[13]Lindiwe S *Meeting the Challenges of Forced Migration in Majodina Zonke* : *The Challenges of Forced Migration in Southern Africa* ed (2001) Africa Institute of South Africa 6.
[14]Onuoha E Human Rights and Refugee Protection in South Africa 1994-2004 LLM Thesis University of the Witwatersrand (2006) 97.

procedures are filled with unintentional discrimination to the extent that public health policies and programmes should be regarded as discriminatory till the contrary is proved. In other words, public health policies are potentially a threat to the enjoyment of human rights.[15] According to Brawley, for the client the most important dimensions of quality are technical competence, interpersonal relations, accessibility and amenities. Technical competence refers to the skills and actual performance of the health providers in regard to examinations, consultations and other technical procedures.[16] Tumushabe has argued that the Ugandan success story on HIV/AIDS became a critical approval and marketing issue for the government. He found a very weak healthcare system without the capacity to care effectively for the deluge of AIDS patients.[17] Pillsbury argues that fighting AIDS requires political commitment as well; the vital component in Uganda success but a missing ingredient in other countries in order to find solutions.[18] Williams et al argue that migration is a key neglected factor in the spread and prevalence of HIV/AIDS in South Africa; this could be said for other places as well.[19] Decosas elaborating on this theme writes: "Clearly the disease strikes hardest where poverty is extensive; gender inequality is pervasive and public." He argues: if we are really serious about recognising the social dimension of AIDS, then we have to recognise that the way communities feed themselves, the way they earn their living, the way they pray together, the way they look after their children and their elderly, the way they care for their sick, the way they govern themselves are all determinants of how they experience HIV and how they cope with AIDS.[20] Webb argues that awkward political questions must be raised about resources, empowerment and human rights, and incorporated into a long-term intervention approach.[21] This research aims to examine the

[15] Mann J 'Medicine and Public Health, Ethics and Human Rights' (1997) 27 *TheHasting Center Report* 9.
[16]Brawley M The client perspective: What is quality health care service? A literature review Kampala Uganda: Delivery of Improved Services for Health (2000) *USAID Cooperative Agreement* 2.
[17]Tumushabe J 'The Politics of HIV/AIDS in Uganda Social Policy and Development Programme Paper(2006)28 *United Nations Research Institute for Social Development'* 8 available at *http://www.unrisd.org/unrisd/website/document.nsf/240da49ca467a53f80256b4f005ef245/86cb69d103fcf94ec125723000380c60/\protect\char"0024\relaxFILE/tumushabe-pp.pdf*. [accessed on 23 June 2014].
[18]Pillsbury B 'HIV/AIDS and Behavior Change: Let's Add PC to ABC' (2003) 44 *Anthropology News* 7.
[19]Crush J 'Spaces of Vulnerability: Migration and HIV/AIDS in South Africa' (2002) 24 *Cape Town: Southern African policy Migration project* 3.
[20]Decosas J 'The Social Ecology of AIDS in Africa UNRISD HIV/AIDS and Development Project' (2002) Geneva: United Nations Research Institute on Social Development available at *http://www.unrisd.org*[accessed on June 29 2014].
[21]Webb D *HIV and AIDS in Africa* ed (1997) South Africa: Natal Press 13.

several regional instruments for the protection of the rights of refugees living with HIV in access to health in order to determine the gaps that exist in the regional protection and to recommend systems which may address this insufficiency.

1.4 Objectives of the Study

This research aims:

1. To examine the challenges hindering access to HIV treatment by refugees in South Africa and Uganda.

2. To examine whether laws and policies adopted by the governments of South Africa and Uganda to realise access to HIV treatment for refugees are consistent with these countries obligations under international law.

3. To provide recommendations on specific measures that should be adopted by States in mainstreaming the rights of refugees living with HIV.

1.5 Research Questions

The specific research questions are:

1. What are the existing normative frameworks to realise access to HIV treatment for refugees at the international level?

2. What are the factors that impede or enhance access to HIV treatment for refugees in South Africa and Uganda?

3. What are the legal frameworks to realise access to HIV treatment for refugees in South Africa and Uganda?

4. Are the legal frameworks to realise access to HIV treatment in South Africa and Uganda consistent with these countries obligations under international law?

1.6 Significance of Study

The study intends to contribute to the academic discourse on access to treatment by refugees living with HIV under Economic, Social and Cultural Rights and human rights instruments at international level especially from a practical point of view. It is a significant step in analysing the role and obligations of South Africa and Uganda, for effective implementation of Economic, Social and Cultural Rights and other human rights instruments at the international level. Furthermore, this research paper will shed light on policies and engagement between civil society and government toward the promotion of Economic, Social and Cultural Rights and human rights instruments at international level. In addition, it is hoped that this research paper will add to the understanding on the legal response that demand to be given towards protection of the right to health for refugees with HIV, and addressing the access to health at regional level.

1.7 Research Methodology

In order to answer the research questions the research will involve consulting international human rights treaties, national constitutions, laws and policies directly or indirectly relating to refugees in the two countries. University databases, journals and books that will be used in this research include forced migration journal studies, unions for refugee women, centre for migration and reports on interviews and society and refugee law project. Legal instruments will also be using to assess the theoretical foundation of this dissertation and to get a sound and contextual basis on the topic under review. A combination of comparative and analytical methods will be applied in this research.

1.8 Limitations of the Study

Though aware of the fact that the study of the realisation of access to essential treatment requires a multi-disciplinary approach, this research paper will focus on access to essential treatment from a human rights perspective. This study will look at the refugee issue in accessing health care in South Africa and Uganda since the coming into force of ECSR and other human rights instruments at international level.

1.9 Overview of Chapters

This study in addressing the social economic rights of refugees is divided into five chapters that attempt to address the question:

Chapter 1 gives the background study

Chapter 2 examines the duty of domestic South African law with respect to the rights to access on health care for refugees living with HIV and examines the international framework in South Africa.

Chapter 3 examines the duty of domestic Ugandan law with respect to the rights of access to health care for refugees living with HIV and examines the international framework in Uganda.

Chapter 4 examines the jurisprudence of the African human rights procedure in order to discover whether there has been suitable understanding of the rights to health care of refugees living with HIV. It further emphasises the challenges that exist as an outcome of the absence of mainstreaming of the particular requirements of refugees in accessing treatment in the regional response to HIV.

Chapter 5 gives conclusions and recommendations of the research to overcome the obstacles to the realisation of ESCR and human rights instruments at international level of refugees in accessing health care in South Africa and Uganda.

CHAPTER 2

INTERNATIONAL AND REGIONALE FRAMEWORK OF THE RIGHT TO HEALTH AND RELEVANCE FOR REFUGEES

2.1 Introduction

This chapter will examine the internationally recognised right to health and assess whether South Africa and Uganda are living up to their obligations to realise this right for refugees in the context of HIV/AIDS treatment under international law. As will be shown below, the right to the highest attainable standard of health is a human right recognised in international human rights law. Therefore the International Covenant on Economic, Social and Cultural Rights is widely considered as the foundation for the protection of the right to health and also recognises 'the right for everyone to enjoy the highest attainable standard of physical and mental health which precludes discrimination to access health care.' It is important to note that the Covenant on Economic, Social and Cultural Rights gives both mental health, which has often been neglected and physical health equal consideration. The chapter will demonstrate how creative judicial interpretation can change local policy and respect the right to health, even when the right is not respected in constitutional law.

2.2 Concept of Right to Health

The right to health is fundamental to the physical and mental wellbeing of all individuals and is a necessary condition for the exercise of other human rights, including the pursuit of an adequate standard of living.[22] There is no conflict in the use of the words 'right to health' and 'right to health care' as long as we know that the right to health is not meant to guarantee an individual good health. The fundamental aim behind these normative words is the realisation of the highest attainable standard of health.[23] However the right to health is more suitable shorthand to cover the specified language and recommendations that are found in international treaties including the Universal Declaration of Human Rights (Universal Declaration) and the International Covenant

[22]General Comment N 14 2000 The Right to the Highest Attainable Standard of Health, (Article 12 of the International Covenant of Economic, Social and Cultural Rights) UN Committee on Economic, Social and Cultural Rights, 2000 para 1.
[23]Ngwena C & Cook R 'Rights Concerning Health eds (2005) Pretoria University Press 107.

on Economic, Social and Cultural Rights (ICESCR).[24] There is no uncertainty, that the right to health contains the right of access to treatment including HIV/AIDS drugs. Through their nature, these rights have essential social and economic aspects as most of them reflect specific areas of basic needs or delivery of particular goods and services.[25] It is in that light that the right to health, which contains the right of access to HIV/AIDS treatment, has to be understood.

2.3 The right to access health in international law

The World Health Organisation (WHO) broadly defines health as a State of complete physical, mental and social wellbeing.[26] To emphasise, Higgins says that 'human rights are not certainly legal rights but are rights which all individuals hold by benefit of the human situation. They are not related upon grant or authorisation of the State and they cannot be extracted by order of the State.'[27] The earliest modern human rights instrument, the Universal Declaration of Human Rights (the Universal Declaration)[28] in Art 25 of the Universal Declaration of Human Rights states:

> '(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. (2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.'[29]

The Declaration develops the bases for implementing primary health care systems, which have implications for the observance of the right. While this instrument is not binding, it does

[24]Ngwena C & Cook R (2005) 107.
[25]Mubangizi J *The Protection of Human Rights in South Africa: A Legal and Practical Guide* 2ed (2013) South Africa: Juta Law 118.
[26]Promoting Mental Health Concepts Emergency Evidence Practice (2004) 11 available at *http://www.who.int/mental_health/evidence/en/promoting_mhh.pdf*
[27] Kuper J 'Law as a Tool: The Challenge of HIV/AIDS' (2004) 1 *Crisis States Research Centre* 24.
[28]'The Universal Nations (UN) of Universal Declarations of Human Rights (UDHR) General Assembly in Resolution' 217 A (III) 1948 available at *http://www.un.org/en/documents/udhr/*[accessed on 20August 2014].
[29] Art 25 of the UDHR.

represent a further commitment on the part of States in respect of the right to health and[30] establishes the framework for an integrated policy aimed at securing its enjoyment.[31]

The Universal Declaration has come to develop important moral and legal force and to give the inspiration of many national constitutions.[32] The right of everyone to the enjoyment of the highest attainable standard of physical and mental health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social conditions this is also laid down in the International Covenant on Economic, Social and Cultural Rights (ICESCR).[33] The countries that have ratified the Covenant must refrain from denying or limiting equal access for all persons to preventive, curative and palliative health services including 'refugees'.

2.4 The Convention and the Protocol Relating to the Status of Refugees

The 1951 Convention of Refugees and the 1967 Protocol Refugees are the two main instruments that specifically provide for the protection of refugee rights under international law. The 1951 Convention is designed to consolidate existing international instruments relating to refugees and to extend their scope to further groups of refugees.[34]

The 1951 Convention was intended to redress the refugee problems that existed at the time of its formulation and had geographic boundaries in its function. This led to the adoption of the 1967 Protocol Relating to the Status of Refugees. The protocol to the 1951 Convention was adopted by the United Nations in 1967 to extend refugee protection to developing countries and to tackle new refugee situations worldwide. The purpose of the Protocol was to expand the 1951 international convention to embrace all refugees thus eliminating the temporal and geographical

[30] 'The Right to Health' available at *http://www1.umn.edu/humanrts/edumat/IHRIP/circle/modules/module14.htm*[accessed on 22 August 2014].
[31]'The Right to Health' available at *http://www1.umn.edu/humanrts/edumat/IHRIP/circle/modules/module14.htm*[accessed on 22 August 2014].
[32] 'The Universal Nations (UN) of Universal Declarations of Human Rights (UDHR) General Assembly in Resolution' 217 A (III) 1948 available at *http://www.un.org/en/documents/udhr/*[accessed on 20August 2014].
[33]CESCR the UN General Assembly in Resolution, 1966 CESCR 2200 A (XXI) (1966).
[34] Weiss P 'The International Protection of Refugees' (1954) 48 *The American Journal of International Law* 193.

limitations in the scope of the previous convention.[35] The 1951 Convention Relating to the Status of Refugees states:

'Refugees shall be accorded the same treatment as nationals in relation to maternity, sickness, disability and old age.'[36] Therefore, the States of host countries have said before international human rights bodies or in national legislation that they cannot or do not wish to offer the same level of protection to refugees as to their own citizens.[37] Consequently, most countries have stated their health obligations towards non-citizens in terms of 'essential care' or 'emergency health care' only. Since these notions mean different things in different countries, their understanding is often left to person health staff. Methods and laws may therefore be discriminatory.[38]

The Committee on the Elimination of Racial Discrimination in its General Recommendation has underlined that the obligations of States require, among other things, the removal of obstacles that prevent the enjoyment of Economic, Social and Cultural Rights (ESCR) by non-citizens in the area of health.[39] The Committee on Economic, Social and Cultural Rights (CESCR), in its General Comment 14 on the right to the highest attainable standard of health, state that 'States Parties should respect the right of non-citizens to an adequate standard of physical and mental health by, inter alia, refraining from denying or limiting their access to preventive, curative and palliative health services.'[40]

Consequently, refugees' right to health is closely related to and dependent on their working and living situations and legal status. In order to widely address refugees' health matters, States

[35] Blavo E *The Problem of Refugees in Africa: Boundaries and Borders* (1999) 13.
[36]United Nations High Commissioner of Refugees (UNHCR) of the Convention Relating to the Status of Refugees, 1951 Resolution 2198 (XXI) (1951).
[37]Office of the United Nations High Commissioner for Human Rights (OCHR), World Health Organisation (WHO) 'Right to Health':Fact Sheet 20 available at *www.ohchr.org/Documents/Publications/Factsheet31.pdf [accessed on 22 August 2014]*.
[38]Office of the United Nations High Commissioner for Human Rights (OCHR), World Health Organisation (WHO) 'Right to Health':Fact Sheet 19 available at *www.ohchr.org/Documents/Publications/Factsheet31.pdf [accessed on 22 August 2014]*.
[39]UN Committee on the Elimination of Racial Discrimination, General Recommendation 30, Discrimination against Non-citizens, 2004 U.N. Doc. CERD/C/64/Misc.11/rev.3 (2004).
[40]Committee on Economic, Social and Cultural Rights, General Comment 14, The Right to the Highest Attainable Standard of Health, 2000 U.N. Doc. E/C.12/2000/4 (2000) reprinted in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.6 85 (2003).

should also take steps to realise their rights to, among other things, suitable accommodation,[41] safe and healthy working conditions,[42] an suitable standard of living and food.[43]

2.5 International Covenant on Economic, Social and Cultural Rights

Art 12 of International Covenant on Economic, Social and Cultural Rights (ICESCR) is the most vital international provision on the right to health;[44] being clear about the recognition of the right to health and the attendant obligations on the part of the State. The obligations are notably in respect of providing curative care but also preventive care. It states:

> '1. The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. (c) The prevention, treatment and control for epidemic, endemic other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.'[45]

An appropriate understanding of these obligations envisages a situation where the States would provide population accessibility to health care services. In this case States are obliged to establish systems of urgent healthcare and they are cooperatively and respectively enjoined to: make available relevant technologies; implement and enhance immunisation programmes and create conditions which would assure to all medical services and medical attention in the event of sickness.[46]

In the refugee context, this reveals an obligation to provide health rights, without mention of citizenship or legal residency,[47] thereby reiterating the importance of non-discrimination. While international human rights law provides a solid legal basis for health rights, it is subject to a number of weaknesses which have limited its impact. Its enforcement mechanisms are notoriously weak. In the case of ICESCR, they are limited to reporting by countries to the treaty

[41] ICESCR Article 11.
[42] ICESCR Articles 6 - 8.
[43] ICESCR Article 11.
[44]Chapman A 'Core Obligations Related to the Right to Health and their Relevance for South *Africa'* ed (2002) in Brand D & Russell S eds (2002) *Exploring the Core Content of Socio-Economic Rights: South African and International Perspectives* 40.
[45] ICESCR Article 12.
[46]General Comment 14 Para 17.
[47]Roberts B 'HIV/AIDS, Conflict and Forced Migration (2004) *FMO Thematic Guide: Forced Migration and Health'* 15 available at *http://www.forcedmigration.org/research-resources/expert-guides/hiv-aids-conflict-and-forced-migration*[accessed on 26 August 2014].

body. It is because refugees often remain on the periphery of effective protection due to their lack of citizenship, especially when hosted by States unwilling or unable to ensure the protection of the rights of their own citizens.[48]

The collection of human rights instruments and documents that deal with the right to health is huge. At the international level, the following treaties contain provisions that address the right to health: the Convention on the Rights of the Child (CRC),[49] and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)[50].

2.5.1 General comment 14

The CESCR has identified these numerous obligations within the right to health in its GC 14.General Comment 14 stipulates the most comprehensive description of the scope of States responsibility under the United Nations with respect to the right to health and is thus definitive of the rights and obligations arising from the ICESCR. The CESCR in General Comment 14 notes:

> 'States have an obligation to respect the right to health by refraining from denying or limiting equal access for all persons, including refugees to preventive, curative and palliative health services.'[51]

The Committee of ESCR noted that States could not be expected to guarantee good health for the individual and that the right would therefore have to be measured against the criteria on whether the State had provided certain goods and services.[52] The Committee outlined the essential elements of the right to health, which are availability, accessibility, acceptability and quality.[53] Availability demands that the public health care facilities, goods and services be offered in sufficient quantity. Accessibility has tree overlapping dimension, namely, non-discrimination, physical accessibility and information accessibility. Acceptability demands that the health care

[48]Roberts B 'HIV/AIDS, Conflict and Forced Migration (2004) *FMO Thematic Guide: Forced Migration and Health'* 16 available at http://www.forcedmigration.org/research-resources/expert-guides/hiv-aids-conflict-and-forced-migration[accessed on 26 August 2014].
[49]Committee on the Right of the Child, Adolescents Health and Development in the Context of the Convention on the Right of the Child, General Comment N 4 CRC/GC/2003/4 (2003).
[50]General Recommendation 24 of CEDAW on Women and Health UN GAOR, 1999, Doc A/54/38 Rev 1 (1999).
[51] CESCR General Comment 14 para 28-29.
[52] General Comment 14 para 7.
[53]General Comment 3 the Nature of States Parties Obligations art 2 Para 1 of the Covenant, 1990 UN Doc E/1991/23 (1990) para 1.

services that are offered be ethically and culturally acceptable. Quality ensures that it is not mere quantity that matters. Service must also be medically appropriate and of good quality.

Therefore, the right to health requires that health care facilities, goods and services be affordable for all.[54] Refugee's often suffer on account of their inability to obtain health insurance and they resist seeking medical treatment because of associated costs, inability to miss work, inability to find childcare and problems of transportation.[55] In some countries migrant workers have to pay up to twice as much as the residents for health care services.[56] Payment for health-care services according to the Committee, as well as services related to the underlying determinants of health must be based on the principle of equity, ensuring that these services, whether privately or publicly provided are affordable to all.[57].

2.5.2 Other United Nations Treaties that Directly Address the Right to Health

Some groups or individuals, such as, children, women, or refugees living with HIV/AIDS, face specific hurdles in relation to the right to health. Considering health as a human right requires specific attention to be given to different individuals and groups of individuals in society, in particular those living in vulnerable situations. Similarly, States should adopt positive measures to ensure that specific individuals and groups are not discriminated against. The CEDAW, in its General recommendation 24 has contributed to the elucidation of the obligations obliged by the right to health in the specific context of Art 12 of CEDAW.[58] Art 12 states:

> '(1) States parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services including those related to family planning.'

General Recommendation 24 has strengthened the significance of the right to health in respect of the specific conditions of women and their historically vulnerable status. Its attention is the

[54]General Comment para 12(b).
[55]International Migration, Health and Human Rights (2003) World Health Organisation (WHO) 25.
[56] Amnesty International, Trapped: The Exploitation of Migrant workers in Malaysia, ASA 28/002/2010,2010; and Amnesty International, Disposable Labour, Rights of Migrant Workers in South Korea, 2009,AI Index: ASA 25/001/2009.
[57]Amnesty International, Trapped: The Exploitation of Migrant Workers in Malaysia, ASA 28/002/2010, 2010; and Amnesty International, Disposable Labour, Rights of Migrant Workers in South Korea, 2009, AI Index: ASA25/001/2009.
[58]Durojaye E 'The Approaches of the African Commission to the Right to Health under the African Charter' (2013) 17 *Law Democracy and Development* 395 http://dx.doi.org/10.4314/ldd.v17i1.19 [accessed on 26 August 2014].

eradication of discrimination and the realisation of equality for women in the sphere of health. In the specific conditions of women, services must respond to the specific essentials of vulnerable and marginalised group (refugees). However States should take into account that women are disproportionally vulnerable to gender discrimination and gender violence among other social ills.[59]

Both ICESCR and CEDAW demand the eradication of discrimination against women in health as well as ensures of equal access for women and men refugees to health-care services. Redressing discrimination in all its methods, including in the provision of health and guaranteeing equality between men and women are vital aims of treating health as a human right. In this respect, the CEDAW in Art 14 explicitly calls upon States to guarantee that 'women refugees in rural areas participate in and advantage from rural development and have access to suitable health-care facilities, counseling and services in family planning.'[60]

Regarding the right to health of CRC, child refugees face specific health challenges related to the stage of their physical and mental development, which makes them especially vulnerable to malnutrition and infectious diseases and when they reach adolescence, to sexual, reproductive and mental health problems. The Convention on the Rights of the Child in Art 24 states:[61]

> '1. States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health-care services. 2 (*b*) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care.'

In this context both ICESR and CRC recognise the obligation on States to reduce infant and child mortality and to prevent disease and malnutrition. In addition, Infants' health is so closely related to women's reproductive and sexual health that the CRC directs States to guarantee access to

[59]Ngwena C & Cook R Rights Concerning Health eds (2005) Pretoria University Press 120.
[60]General Recommendation 24 of CEDAW on Women and Health UN GAOR, 1999, Doc A/54/38 Rev 1 (1999) Art 14.
[61]Committee on the Right of the Child, Adolescents Health and Development in the Context of the Convention on the Right of the Child, 2003 General Comment N 4 CRC/GC/2003/4 (2003). Art 24.

essential health services for the child refugees and his/her family, including pre- and post-natal treatment for mothers.[62]

2.5.3 Progressive Realisation

In this regard Art 2(1) of ICESCR provides:

> 'Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.'

The Committee on Economic Social and Cultural Rights has observed that this Article is essential to the understanding of the nature and extent of States obligations under various obligations.[63] However, steps towards achieving their realisation must be taken before or within a reasonable time after ratification. Though legislation will frequently be indispensable, it is not a mandatory means for the realisation of rights under ICESCR. Therefore States should ensure three essential elements: first, is a predictable legal domain with domestic legislative patterns conforming to the demands arising from these rights: secondly, an independent, impartial judiciary and accessible by all persons, and thirdly, the adoption of targeted, appropriate, and effective policies.[64]

The steps must be targeted, concrete and transparent in this regard. The State has an obligation to move as expeditiously and effectively as possible towards full realisation of the rights making maximum use of available resources. In addition the guarantee to exercise a right to health must be in line with the principles of availability, accessibility, quality and acceptability.[65]

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[62]Office of the United Nations High Commissioner for Human Rights (OCHR), World Health Organisation (WHO) 'Right to Health':Fact Sheet 20 available at *www.ohchr.org/Documents/Publications/Factsheet31.pdf [accessed on 22 August 2014]*.

[63] Article 2 of the CESCR.

[64] Leckie S 'Another Step Towards Indivisibility: Identifying Key Features of Violations of Economic, Social and Cultural Rights' (1998) 105-6.

[65] Ngwena C & Cook R 'Rights concerning health' In Brand & Christof Heyns Eds (2005) *Socio-Economic Rights In South Africa* Pretoria: University Law Press Pretoria 115.

2.5.4 Limitations on Right to Health

Under Art 23 of the 1951 Convention relating to the Status of Refugees, 'States Parties shall accord to refugees lawfully staying in their territory the same treatment with respect to public relief and assistance as is accorded to their nationals, including medical care.'[66] Country of refuge are therefore responsible for guaranteeing equal and non-discriminatory access to health service including care for HIV/AIDS, for refugees whose requests are being treated.[67]

Art 4 of the ICESCR states that: the States Parties to the present Covenant recognise:

> 'In the enjoyment of those rights provided by the State in conformity with the present Covenant, the State may subject such rights only to such limitations as are determined by law only in so far as this may be compatible with the nature of these rights and solely for the purpose of promoting the general welfare in a democratic society.'

The different approaches adopted in Art 4 may infer that refugees' 'right to access healthcare services' can be limited by any limitations pescribed in Uganda and South Africa regarding access to HIV/AIDS treatment. The notion of 'access' is critical for it is not just about the availability of drugs but the facility to access them. Therefore, it has been said that accessibility means physically accessibility which is financially reasonable.[68] In other terms, access to drugs can only be guaranteed if a sustainable supply of affordable drugs can be assured, that is, a regular current supply of affordable drugs.[69] It highlights that, from a public health view, access to essential drugs depends on (i) rational selection and use of drugs; (ii) sustainable adequate funding; (iii) reasonable prices and (iv) reliable health and supply systems.[70] It must provide other health care facilities and services; and access to drugs has to be provided on a non-discriminatory basis considering the most vulnerable and marginalised sections of the population.[71]

[66]'The Convention of Refugees' available at: *http://www.unhchr.org* [accessed on 22 August 2014].
[67]Strategies to Support the HIV-Related Needs of Refugees and Host Populations (2005) United Nations Programme on HIV/AIDS (UNAIDS) 9.
[68]Hassim A et al *Health and Democracy: A Guide to Human rights, Health Law and Policy in Post-apartheid South Africa* (2007) South Africa: Cape Town 438.
[69]Hassim A et al (2007) 438.
[70]Yamin E 'Not Just a Tragedy: Access to Medications as a right under international law' (2003) 21 *Boston University International Law Journal* 337.
[71]Committee on Economic, Social and Cultural Rights, General Comment 14 para 12.

2.6 Regional Protection on the Right to Health for Refugees

International and regional systems were generally planned to have universal function to all human beings.[72] This means that though some regional systems may not make particular reference to the condition of refugees, it does not exclude application to them because they too are eligible for these rights which are indissoluble and inherent in every human being. However the right to seek and enjoy asylum means that everyone has the right to seek and enjoy asylum from persecution in other countries.[73] Under the 1951 Convention relating to the Status of Refugees and under customary international law, States cannot in accordance with the principle of non refoulement, return a refugee to a country where he or she faces persecution or torture.[74] Thus, States may not return a refugee to persecution on the basis of his or her HIV status. Furthermore, they cannot adopt special measures, such as mandatory HIV testing, to reject HIV-positive persons from being considered for, or accorded refuge.[75]

2.6.1 African Charter

In 1981 the African Union (AU) adopted the African Charter on Human and Peoples' Rights (ACHPR). It is the main instruments upon which the African human rights method is founded. It has been expressed as a unique catalogue of substantive rights that belong to individuals and population in Africa as it represents the African cultural perception.[76] The ACHPR unequivocally created States' obligations which regard to rights and freedoms. These rights included the right to health for all. By using the phrase 'for all' it can be persuasively concluded that this right included refugees. The ACHPR is thus an additional source of refugees' protection in Africa.[77] The ACHPR Commission has interpreted the ACHPR roughly to promote and protect the rights of refugees and has highlighted that African States that are not parties to the

[72]Article 1 of Universal Declaration all human beings are born free and equal in dignity and in the rights.
[73] Art 23 of the UDHR.
[74] United Nations High Commissioner of Refugees (UNHCR) of the Convention Relating to the Status of Refugees, 1951 Resolution 2198 (XXI) (1951).
[75]'Handbook on HIV and Human Rights for National Human Rights' (2007) 676 *United Nations. Office of the High Commissioner for Human Rights* 8 available at*https://books.google.co.za/books?isbn=9211541816[accessed on 22 November 2014]*.
[76]Mutua M 'The Banjul Charter and the African Cultural Fingerprint: an Evaluation of the Language of Duties' (1995) 35 *Virginia Journal of International Law* 339.

Convention but are parties to the Charter are obliged to respect refugee rights.[78] However the AU constitutive Act states that one of its aims is 'to work with relevant international associates in the abolition of preventable sicknesses and the promotion of good health on the land.'[79]

Although the Constitutions of most African countries do not explicitly recognise the right to health as a justiciable right,[80] most of these countries have ratified numerous international and regional human rights systems guaranteeing the right to health. Some of these instruments include the African Charter on Human and Peoples' Rights (African Charter);[81] and the African Charter on the Rights and Welfare of the Child (African Children's Charter).[82]

It can be deduced from the above discussion that despite the fact that the regional treaty is silent on refugees' rights, refugees can still demand their right to access healthcare services under this system.

In this regard, an important notion that can be learnt from the practice in other States is that there is a need to make particular provision for the rights of refugees in access to health.

2.6.2 African Regional Treaties and Refugees Rights to Access Healthcare Services

The African Charter on Human and Peoples' Rights enshrines and protects economic, social and cultural rights on the same basis as civil-political rights. Art 16 protects the right of the individual to the highest attainable standard of health and Art 16(2) sets out that 'States Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick'.

However, in the *Purohit and Moore v Gambia* case the African Commission implied the limitation of maximum available resources to the right to health under the African

[78] Ddamulira J 'The African commission on human and people's rights and the promotion and protection of refugees' rights' (2009) 9 *African Human Rights Law Journal* 182-83 available at *http://0journals.sabinet.co.za.innopac.wits.ac.za/WebZ/images/ejour/ju_ahrlj/ju_ahrlj_v9_n1_a8.pdf?sessionid=01-385641702537244&format=F* [accessed on 2 October 2014].
[79] Art 3(n) of the Constitutive Act.
[80] Balogun V & Durojaye E 'The African Commission on Human and Peoples' Rights and the promotion and protection of sexual and reproductive rights' (2011) 11 *African Human Rights Law Journal* 370.
[81] African Charter on Human and Peoples' Rights,1981OAU Doc CAB/LEG/67/3/Rev 5 (1986).
[82] African Charter on the Rights and Welfare of the Child, 1990 OAU Doc CAB/LEG/24.0/49 (1999).

Charter.[83]According to the African Commission, the right to health is not limited to access to health care but to every other supporting treatment, management or service which promotes the highest attainable standard of health for everyone regardless of age, sex or gender.[84]

The ACHPR Commission has played the main role in the interpretation and application of the right to health. In addition, it has assisted in establishing the structures for exercising the right to access health care and the right to health in general. In the *Zaire* case,[85] the Commission held that the failure of the government to deliver services such as water and electricity and a shortage of medicines also amounted to violation of the right to health. Regrettably in this case the Commission did not give the right to health its fullest interpretation.

However in *Social and Economic Rights Action Centre (SERAC) and Another v Nigeria*[86], the Commission observed that, rights create at the very least three duties: to protect, promote and fulfil. These duties generally apply to all rights and the need for enjoyment of some of the rights requires actions from States in the form of more than one of the duties above. In the *SERAC case*[87], the African Commission found that the adverse environmental health constituted breaches of the right to health and the right to a healthy environment guaranteed by Art 16 and 24, respectively of the African Charter.

The case in point that would be relevant to refugees in detention is the *Nigerian case*.[88] In this case the Commission observed that the responsibility of the government to deliver health care is heightened in cases where individuals are in custody. Therefore to deny a detainee access to doctors while his or her health is deteriorating would amount to violation of Art 16.[89] Although the Commission main role is enforcement of refugees rights, the decisions of the commission have been established with regard to ACHPR and not the Convention of 1969. Therefore, it recommends that in matters relating to refugee rights the Commission should always invoke the

[83] Communiqué 241/200, decided at 33rd Ordinary Session of the African Commission (2003).
[84]*Purohit & Another v The Gambia* 2003 AHRLR 96 (ACHPR).
[85]*Free Legal Assistance Group v Zaire* 2000 AHRLR 74 (ACPHR 1995).
[86]*Social and Economic Rights Action Centre (SERAC) & another v. Nigeria* (2001) AHRLR 60 (ACHPR) Para 44.
[87]*Purohit and Another v The Gambia (*2003) AHRLR 96 (ACHPR 2003). *Social and Economic Rights Action Centre (SERAC) and Another v Nigeria* (2001) ACHLR 60 (15TH Annual Activity Report) (*SERAC* case).
[88]'Media *Rights Agenda and Constitutional Projects v Nigeria*, twelfth Annual Report of the Commission-1998/1999' available at *http://www1.umn.edu/humanrts/africa/comcases/105-93_128-94_130-94_152-96.html* [accessed on 3 October 2014].
[89]Article7, 29(3), & 60 of the African Court protocol.

provision of the 1969 Convention and the ACHPR and simply make reference to other refugee related instruments where necessary.[90]

Therefore, there is a need to specifically spell out the rights, or at least create provisions that clearly indicate practical ways in which refugees can enjoy their rights in access to health. For instance, no provision is made for the specific needs of refugees in relation to HIV/AIDS related matters, and this, among many other short of comings, does not promote responses to the peculiar needs of refugees in order to ensure the enjoyment of equality.

2.7 Conclusion

Like all other socioeconomic rights, the right to health cannot be realised unless the institutions of the current global order have the capacity to intervene in the activities of those who currently exercise their freedoms to increase their wealth, no matter the social conditions that others must suffer. Since globalisation increasingly exposes us all to health risks, the failure to undertake institutional reform will lead to more epidemics, chronic disease and an environment where the means of leading a dignified and healthy life are less possible.

Therefore, the challenges that face refugees in the context of access to health requires specific address which cannot be adequately provided through an international instrument, rather, in order to eradicate all preventable dangers which refugees are exposed to by virtue of their exposure to HIV. There is a need to develop regional methods

It is from this light that the next chapter will discuss at the status of the international right to health care framework within the two case studies of South Africa and Uganda.

[90]Ddamulira J 'The African commission on human and people's rights and the promotion and protection of refugees' rights' (2009) 9 *African Human Rights Law Journal* 189 available at *http://0journals.sabinet.co.za.innopac.wits.ac.za/WebZ/images/ejour/ju_ahrlj/ju_ahrlj_v9_n1_a8.pdf?sessionid=01-385641702537244&format=F* [accessed on 2 October 2014].

CHAPTER 3

ACCESS TO HEALTH FOR REFUGEES AND THE INTERNATIONAL FRAMEWORK IN SOUTH AFRICA

3.1 Introduction

This chapter will start by setting out the present status of the right to health care for refugees in South Africa particularly in the light of HIV. With a view to establish to which extent the international obligations emanating from this right have been explored at the national level, the chapter examines the activities towards respect, protection and fulfilment of the right. This chapter will also show how access to health care in the government of South Africa. Those without proper right to be in South Africa cannot depend on international human rights such as the Convention of Refugees. refugees in South Africa are denied access to treatment. As will be demonstrated below and in the following chapters, in the perspective of HIV this is properly illegal, in defensible and very harmful to people and public health from a human rights perception.

3.2 The Status of the Right to Health in South Africa

Regard for people's rights is vital for current answers to HIV as violations of peoples rights lie at the core of marginalisation and the establishment and continuation of vulnerability.[91] United Nations AIDS (UNAIDS) has acknowledged the value of peoples' rights in the fight against HIV and has stated that it 'has accepted a rights-based approach in its activities, procedures, programmes and activities' and 'functions to mainstream HIV into human rights and vice versa.'[92]

According to Kuper, each state in the world is party to at least one human rights treaty that stipulates for the provision of access to health care.[93] The international human rights treaties thus

[91]United Nations AIDS (UNAIDS)
[92] 'UNAIDS Activities in HIV/AIDS, Human Rights and Law' available at *http://data.unaids.org/UNA-docs/UNAIDS-Activities-Human-Rights-Law_en.pdf*[accessed on 27 August 2014].
[93]Kuper J'Law as a Tool: The Challenge of HIV and AIDS' (2004) *London, Crisis States Research Centre* 27.

afford a legal framework for describing State obligations in protecting HIV linked human rights and a resource for applying human rights protection through legal procedures in the State.[94]

It is with this perspective that South Africa is bound under international law to ensure the realisation of the right of access to HIV drugs for those who need them. This is because the obligations of South Africa and Uganda under international law extend to ensuring sustained and equal access to comprehensive treatment and care, including HIV drugs.[95] This has to be within the framework of General Comment 14 which developed the minimum core content of the right to health.

3.2.1 Refugee Act

The South African Refugees Act 130 of 1998 is vital for this study as it provides that refugees are entitled to the rights enshrined under the Bill of Rights in the Constitution. Furthermore, s 27 (g) of the Refugees Act 130 of 1998 makes it abundantly clear that refugees in South Africa are to be given the same rights of access as everyone else in the country: Refugees are entitled to receive from time to time the same basic health services with the inhabitants of the Republic.[96]

First, South African health professionals must abide by their Constitution, the Refugee Act 130 of 1998 and other binding legal instruments that provide the right to access health and ARV treatment for refugees. Equally important, the government is required to enforce these laws against non-compliant health administrators and hospitals. Secondly, the government should create more health care services near refugee camps, with an objective of prevention and care. The institution of these services will not only encourage refugees to pursue treatment, but will also encourage HIV positive individuals to remain on treatment, providing them with medication, psychological therapy and follow- up communications with health specialists.[97]

[94]MacNaughton G 'Women's Human Rights related to health care services in the context of HIV/AIDS, Health and Human Rights' (2004) 5 *Working Paper: London, The International Centre for the Legal Protection of Human Rights* 15.
[95] 'General Comment 3: HIV/AIDS and the Rights of the Child' available at *http://www.uniteforchildren.org/files/UNHCHR_HIV_and_childrens_rights_2003.pdf* [accessed on 14 August 2014].
[96]Crush J &Tawodzera G 'Medical Xenophobia: Zimbabwean Access to Health Services in SouthAfrica' (2011) 54 Southern Africa Migration Programmes (SAMP)6.
[97]Randolph K 'The Conflict Surrounding Universal Access to HIV/AIDS Medical Treatment in South Africa' (2012) 19 *Human Rights* 28.

South African health professionals are subject to various State endorsed codes of professional ethical conduct regarding their responsibilities to patients. Art 2.1 of the 1999 National Patients' Rights Charter of the South African National Department of Health asserts, for example, that: 'Everyone has a right to a healthy and same environment….'[98]

Art 2.3 further notes that everyone has the right to access health care services that include timely emergency care (at any health care facility that is open, regardless of ability to pay); treatment and rehabilitation; provision for special needs (in the case of newborn infants, children, pregnant women, the aged, disabled persons, patients in pain, persons living with HIV, or AIDS patients); counselling without discrimination, coercion or violence on matters, such as, reproductive health, cancer or HIV/AIDS, and palliative care that is affordable and effective in cases of incurable or terminal illness. Patients also have a right to 'a positive disposition displayed by health care providers that demonstrates courtesy, human dignity, patience, empathy and tolerance.'[99] These rights are clearly specified as being for 'everyone', not just South Africans.[100]

More recently, Human Rights Watch maintained that South African health care professionals are endangering the health of the country's large foreign population by routinely denying health care and treatment to thousands of asylum seekers, refugees and migrants.[101]

However, the South African Bill of Rights entitles all people living in South Africa to a range of social services regardless of their nationality or legal status. These include access to basic education for children and emergency health care. South Africa has an integrative urban refugee policy whereby refugees are encouraged to self-settle and integrate, rather than be limited to camps. A range of additional rights is provided to such individuals through the Refugee Act (1998) and the South African Constitution, including basic primary health care, adequate housing, the right to work and study and certain forms of public assistance in the form of social grants or other relevant services. [102]

[98]Crush J &Tawodzera G 'Medical Xenophobia: Zimbabwean Access to Health Services in South Africa' (2011) 54 Southern Africa Migration Programmes(SAMP) 6.
[99]Crush J &Tawodzera G (2011) 7.
[100]Crush J &Tawodzera G (2011) 8.
[101]Crush J &Tawodzera G(2011) 8.
[102]Maduna P 'Challenges to the Successful Implementation of Policy to Protect the Right of Access to Health for all in South Africa' (2008) *South Africa: Reproductive Health& HIV Research Unit* 13.

3.2.2 National Health Act

One of the purposes of the National Health Act (NHA) in the South African context is to protect, respect, promote and fulfil the rights of vulnerable groups.[103] The use of the phrase "such as" suggests that the list in s 2(c) (IV) of vulnerable groups is not exhaustive and that it is merely illustrative hence refugees can be included. In addition, the stipulation of eligibility under s 4(3) (b) of the National Health Act also requires the State to provide all people with free primary health care services except for those excluded by the section.[104] By applying the phrase 'all people' in the subsection, refugees were also protected by the subsection. Therefore, refugees as people 'are entitled to all the rights protected under the NHA.[105]

This is all very well, but for the turnaround to be sustainable, new method towards the implementation of a strong Constitution will be needed as there are still many matters to be settled concerning access to HIV/AIDS care, including the availability of ARVs, the high price of the medicines, and inadequate access to generic drugs.

From the above provisions of the laws, it is obvious that refugees' right to access health care services is guaranteed under the South African law. This therefore lays the foundation for refugees' demand for the fulfilments of that right within the parameters set by the Courts.

3.3 The Link between International Human Rights Law and Refugee Law

The international debate over the rights of refugees to access health care in countries of destination is a long one. South Africa is a signatory State but has not yet ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR). In refugee context, the ICESCR states that everyone has rights with regard to health, without mention of citizenship or legal residency. The principle of non-discrimination is also fundamental to human rights law and is of particular significance to both refugees and those living with HIV who frequently suffer from high levels of stigmatisation and discrimination.[106]

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[103]The preamble of the National Health Act and the objects of the Act Section 2.
[104]Section 4(3) (b) of National Health Act (1996).
[105] Section 4(3) (b) of National Health Act (1996).
[106] Roberts B 'HIV/AIDS, Conflict and Forced Migration' (2004) 15 *http://www.forcedmigration.org/research-resources/expert-guides/hiv-aids-conflict-and-forced-migration/fmo036.pdf*[accessed on 17 August 2014].

South Africa is also a part to the Convention on the Status of Refugees 1951, which in Art 20 states that refugees exercise their fundamental rights and freedoms without discrimination and be provided the same care as that provided to local nationals.[107] The Government of South Africa is also bound by local legal obligations to remedy unfair access to ARV treatment. However, a lack of access to these life-saving and sustaining medicines has led to an extensive loss of life and caused untold pain and devastation. The Constitution of South Africa in the Bill of Rights states that everyone shall enjoy the same treatment as citizens in this matter. The Refugee Act emanated from a legal regime that was unlawful and which failed to defend or provide for general refugee rights. The Aliens Control Act is an omnibus piece of legislation purporting to regulate all facets of immigration and migration to South Africa.[108]

3.3.1 Relations between International, Regional and National Laws Regarding Refugees' Rights

Among them is the Convention on the Rights of the Child (CRC).[109] The latter contains one of the most elaborate provisions on the right to health. It is arguably more explicit and clear than many other treaties in its articulation of the right to health as guaranteeing access to health care and conditions suitable for good health.[110] The Convention on the Elimination of All Forms of Racial Discrimination (CERD) also contains provisions recognising the rights to health. Art 5(e) (iv) stipulates that 'States have an obligation to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone to equality before the law in the enjoyment of the right to public health, medical care, social security and social services.'[111] Likewise, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

[107]UNHCR of 1951 of Conventions of Refugees art 20.
[108]Klaaren J 'Immigration, Human Rights and the Constitution' in Crush J & Majapelo R ed *Beyond Control: Immigration and Human Rights in a Democratic South Africa* ed (1998) Cape town and Kingston: Idasa and Southern African migration project.
[109]Committee on the Rights of the Child, General Comment 3, 'HIV/AIDS and the rights of the child' (2003) UN Doc CRC/GC/2003/1.
[110]Committee on the Rights of the Child, General Comment 3: 'HIV/AIDS and the rights of the child' (2003) UN Doc CRC/GC/2003/1.Para 23.
[111]International Convention on the Elimination of All Forms of Racial Discrimination, 1965 General Assembly resolution 2106 A (XX) 1965, Art 5.

obligates States to take all appropriate methods to eradicate discrimination in the field of health.[112]

Lastly, as a State Party to the African Charter on Human and Peoples' Rights, South Africa is bound to defend the rights and freedoms acknowledged within the Charter, without distinction based on race or culture. These rights include the right to life, the right to health, and the right to non-discrimination.[113]

3.4 The Constitutional Framework of South Africa

The constitutional right of access to treatment facilities in South Africa has to be viewed within the perspective of the legacy of the gross discrimination that characterised South African society.[114] However, the right of access to treatment is one of the socioeconomic rights so ambitiously stipulated for in the South African Constitution. The rights and protection of refugees are specifically set out in s 27 of the Refugee Act. South Africa is one of 109 jurisdictions to have embraced the idea of providing for a right concerning health in a substantive and justiciable form, especially in terms of recognition in a national Constitution.[115] The Constitution sets out health care rights in s 27 as follows:

> 'Health care 27 (1) Everyone has the right to have access to –(*a*) health care services, including reproductive health care. (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. (3) No one may be refused emergency medical treatment.'

Other constitutional necessities that directly or indirectly impact on health include s 10 (dealing with human dignity); s 11 (dealing with the right to life); s 28(1) (c) (assuring children the right to basic health facilities); and s 35(2) (e) (stipulating for the right of detainees and sentenced prisoners to conditions of detention that are consistent with human dignity, including 'the supplies, at state expense of … medical treatment.)'[116]

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[112] General Recommendation (GR) 24: 'Art.12: Women and Health', (1999) UN.Doc.A/54//38 para21-22.
[113]African Charter on Human and Peoples' Rights art. 2,1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982).
[114]Ngwena C & Cook R 'Rights Concerning Health' in Brand & Heyns *Socio-Economic Rights in South Africa* eds (2005) Pretoria University Press 149.
[115]Ngwena C & Cook R (2005) 126.
[116]Ngwena C & Cook R (2005) 115.

In this context, while the Constitution does not describe 'health care services', it has been proposed that such services should incorporate appropriate health care, prevention, diagnosis of diseases and vaccination.[117]

4.4.1 Limitation of the Access to Treatment of Refugees in South Africa

Art 12 the International Covenant on Economic, Social and Cultural Rights (ICESCR) stipulates for the 'enjoyment of the highest attainable standard of physical and mental health conducive to living a life of dignity'.[118] South Africa's international legal obligations under the ICESCR also demand the government to sustain the right to health for everyone, including efforts expected with regard to prevention, care and the coordination of programs ensuring everyone health service and health attention in the event of sickness.[119]

According to s 7(2) of the Constitution[120] the State is obliged to respect, protect, promote and fulfil all the rights in the Bill of Rights. The aims and targets of the policy framework are in line with the perception of the progressive realisation to the maximum level of available resources, as required for under ICESCR.[121]

South Africa should also move as expeditiously and effectively as possible towards a full implementation of refugee health policies in accordance with the principles of availability, acceptability, and quality, such implementation will depend on the resources available for health purposes and will be subject to distributive justice. However, with regard to refugees' emergency health care there is a need to meet the obligations immediately as any denial would render the existing policies meaningless.

Nonetheless, the right to health treatment of HIV positive refugees is often violated, as a result of xenophobia. Refugees face challenges when it comes to accessing health care in which refugees are portrayed as carriers of disease and that they tend to place a burden on the public health care

[117]De Waal et al *A Bill of Rights handbook* (2001) 448.
[118]ICESCR Article 12.
[119]International Covenant on Economic, Social and Cultural Rights (ICESCR), 1976 G.A Res 2200A (XXI), art 12.UN Doc A/6316, (1976).
[120]Section 27 (2) of the Constitution of the Republic of South Africa, Act 108 of 1996.
[121]Art 2(2) ICESCR.

system.[122] In addition to this, if the health of urban populations in the framework of HIV and migration is to be improved, there is a need to understand the meaning of 'place' which is where migrants are determines access to basic services, as this forms the primary determinants of the health of the population.[123]

4.4.2 Challenges Faced by Refugees in Access to Health in the Context of HIV in South Africa

Under Art 23 of the 1951 Convention Relating to the Status of Refugees: 'states parties shall afford to refugees *legally living* in their area the equal care with respect to public relief and assistance as is afforded to their nationals, including health care.'[124] States regarding refugees are therefore responsible for guaranteeing same and non-discriminatory access to treatment service, including care for HIV/AIDS, for refugees and asylum seekers whose requests are being processed.[125] Should a person's demand for refugees fail before they are diagnosed with HIV, they are still not permitted to have free care in South Africa.[126]

Hostility towards migrants and refugees makes South Africa one of the most migrant unfriendly countries in the world.[127] As Mary Crewe, Director of the Centre for the Study of AIDS at the University of Pretoria has stated:

> 'HIV and AIDS have brutally exposed the fault lines of our society poverty, gender, equality, violence, lack of access to education, health care and social service as well as the importance of employment and social security.'[128]

In this picture, refugees may be considered to have no access to treatment when social, economic and political or other barriers hinder their full and effective participation in society on an equal

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[122] Vearey J 'Challenging Urban Health: Towards an Improved Local Government Response to Migration, Informal Settlements, and HIV in Johannesburg, South Africa' (2011) 4 *Global Health action* 2.
[123] Vearey J (2011) 2.
[124] 'The Convention of 1951' available at: *http://www.unhchr.ch/html* [accessed on 14 August 2014].
[125]UNAIDS, Strategies to support the HIV-related needs of refugees and host populations, 2005 Geneva p 9.
[126]Crush J &Tawodzera G 'Medical Xenophobia: Zimbabwean Access to Health Services in South Africa' (2011) 54 Southern Africa Migration Programmes(SAMP) 9.

[127]Crush J 'The Perfect Storm: The Realities of Xenophobia in Contemporary South Africa Migration' (2008) 50 *Southern African Migration Project*5.
[128]Viljoen F & Precious S *Human rights under threat: Four perspectives on HIV/AIDS and the law in Southern Africa ed*(2007) 4.

basis with others. The relationship between migration and HIV/AIDS is complex. Although some people think that refugees bring HIV when they enter countries, evidence usually shows the opposite, suggesting that refugees are more vulnerable than local populations.[129] The links between mobility and HIV/AIDS are related to the conditions and structure of the migration process. Therefore refugees in South Africa are further disadvantaged because health professionals often deny them care.[130] Refugees are accused of introducing and spreading diseases. A study of the HIV/AIDS pandemic in South Africa reveals that refugees' rights to access adequate mental and physical health care are protected by international treaties and the South African Constitution. These treaties and Constitution are regularly infringed by medical professionals who deny delivering care. Refugees are also stressed, ridiculed and persecuted by health care workers, when seeking ARV care at local hospitals.[131]

First, a refugees' HIV status remains the object of much stigmatisation and unfair discrimination based upon a lack of information, or misinformation.[132] It is thus imperative that the rights of persons infected and affected particularly women and young girls are protected as their status and position in society renders them particularly vulnerable. Secondly, certain cultural, religious and practices tend to be especially harmful and may increase vulnerability to HIV infection. Therefore, for the equal constitutional protection of religions and cultures it is necessary as part of the constitutional balancing process to introduce measures that regulate harmful practices and protect the fundamental rights of the most vulnerable and marginalised.[133]

Thirdly, society is response to refugees regarding access to treatment in the context of HIV used to be violent. This in turn has deprived them of the assistance they would otherwise have obtained. Therefore discrimination against refugees in respect of access to treatment reinforces the mistaken belief that such action is acceptable and that those infected with HIV/AIDS should

[129]International OrganisationMigration Position Paper on HIV/AIDS and Migration (2002)available at https://www.iom.int/jahia/webdav/shared/shared/mainsite/about_iom/en/council/84/Mcinf252.Pdf. [accessed on 14 August 2014].
[130]Crush J &TawodzeraG 'Medical Xenophobia: Zimbabwean Access to Health Services in South Africa' (2011) 12 *South Africa: SAMP* 26-7.
[131] Randolph K 'The Conflict Surrounding Universal Access to HIV/AIDS Medical Treatment in South Africa' (2012) 19 *Human Rights* 24
[132]'HIV/AIDS, Human Rights and Access to Justice' (2009) 53 available at http://www.justice.gov.za/vg/hiv/docs/2009_discussion-paper7.pdf.[accessed on 14 August 2014].
[133] Mswela M 'Cultural Practice and HIV in South Africa: A legal Perspective' (2009) 12 *PER* 176.

be ostracised and blamed.[134] In turn, this kind of attitude endangers public health because people are unwilling to disclose their HIV status for fear of rejection and marginalisation. All these provisions implemented, can substantially improve the lives of refugees to access treatment and, most of all, the challenges they face with respect to their vulnerability to HIV exposure.

Refugees living with HIV are a very vulnerable group in the South African society. They are vulnerable to opportunistic infections, which can be fatal to them and they are vulnerable to the stigma attached to them by a generally unsympathetic society.[135] They are discriminated against in their personal relationships with others and in institutions, such as, the employment sector, education,[136] banking and insurance. Certain groups of people are even more likely to experience HIV/AIDS discrimination in more severe forms.[137] These groups of people constitute already vulnerable groupings in society and are identified by markers, such as, race, gender, sexual orientation, class, level of education and economic activity. As stated by Heywood M:[138]

> 'The poor, the vulnerable, the unschooled, the socially marginalised, the women and children; those who bear the burden of colonial legacy these are the sectors, which bear the burden of AIDS.'

The prolonged displacement and the disruption of refugees' lives can put them at increased risk of HIV/AIDS, due to factors such as exposure to sexual violence, economic vulnerability and increased contact with surrounding populations with higher HIV prevalence.[139] Therefore as long as refugees in accessing treatment can be identified as vulnerable group, the several groups or types of refugees expose persons living with them to peculiar challenges such as the risk of

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[134]World AIDS Campaign A conceptual framework and basis for action: HIV/AIDS stigma and discrimination (2002-2003) 11 *http://data.unaids.org/Publications/IRC-pub07/jc982-conceptframew_en.pdf*[accessed on 14 August 2014].

[135]'United Nations AIDS (UNAIDS) HIV/AIDS, human rights and law' 132 available at *www.unaids.org/en/in+focus/hiv_aids_human_rights.asp*[accessed 17 August 2014].

[136]Office of the United Nations High Commissioner for Human Rights (OCHR), World Health Organisation (WHO) 'Right to Health':Fact Sheet 19 available at *www.ohchr.org/Documents/Publications/Factsheet31.pdf* *[accessed on 22 August 2014]*.

[137] 'Report on Provincial Consultative Process' available at *http://www.sahrc.org.za/home/21/files/Reports/Combating%20racism%20report_a%20national%20dialogue_%20provincial%20cons.pdf* [accessed on 29 September 2014].

[138]Richter M Preliminary Assumptions on the Nature and Extent of Discrimination against People with AIDS in South Africa Interviews and a Study of AIDS Law Project client files (1993 – 2001) *Aids Law Project* 51.

[139]Spiegel, Miller & Schilperoord Strategies to Support the HIV-related Needs of Refugees and Host Populations: UNHCR/UNAIDS (2005)11.

exposure to HIV. There is an urgent need for regional and national responses to these challenges and promote access to preventive methods which include information and HIV education.

4.4.3 South African Court Interpretations on Socioeconomic Rights

Rights concerning access to health fall within socioeconomic rights, and socioeconomic rights are justiciable in South Africa.[140] While the important South African Court decisions on health, such as, *TAC* and *Soobramoney* did not explicitly deal with refugees, this does not mean that the State has completely special obligations when refugees are concerned.

The case of *Khosa and Others v Minister of Social Development and Others; Mahlaule and Another v Minister of Social Development and Others*[141] have implications not only for access to social security but also access to other socio-economic rights guaranteed to 'everyone' in s 27 (1) of the Constitution, including access to health care services. The Khosa case is the first case to examine the intersection between equality and universal access to socioeconomic rights. The term 'everyone' connotes universality and the State must have sufficient and good reasons for excluding refugees or any other social group from such services. In this regard, *Khosa and Others* cannot be interpreted as referring only to citizens. Had the legislature intended to limit health care rights to citizens it would have worded the section accordingly, as it did with political rights in s 19 and citizenship rights in s 20.[142] Other categories of refugees and other groups that are vulnerable to political and economic marginalisation are to be regarded as included unless the state can come up with sufficient and good reasons why it would be reasonable to exclude them.

The state right to limit access to health care based on available resources was dealt with in *Soobramoney v Minister of Health, KwaZulu-Natal.*[143] In this case, the Court observed that there is no meaningful method in which the right to life can constitutionally be postponed to encompass the right indefinitely to avoid death. The provision of health care services constitutes a positive obligation and is dependent on resources.[144]

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[140]Lienbenberg S 'South Africa's evolving jurisprudence on socio-economic rights: An effective tool in challenging poverty?' (2002) 159 *Socio-Economic Rights Project*.
[141]*Khosa and Others v Minister of Social Development and Others, Mahlaule and Another v Minister of Social Development* (2004) 6 SA 505 (CC).
[142]*Khosa and Others v Minister of Social Development and Others, Mahlaule and Another v Minister of Social Development* (2004) 6 SA 505 (CC).
[143]*Soobramoney v Minister of Health Kwazulu-Natal* (1998) 1 SA 765 (CC).
[144]*Soobramoney v Minister of Health Kwazulu-Natalpara* 57.

It suggested that health care rights, as socio-economic rights, should not be considered as person rights when interpreting their content, but should rather be considered as part of the other socio-economic rights as expounded in *Government of the Republic of South Africa and Two Others v Grootboom*,[145] where the Court maintained that rights require to be interpreted and understood in their social and historical context. The right to be free from unfair discrimination, for example, must be known against our legacy of deep social inequality. The Court added that when determining how to enforce socio-economic rights, this should be done on a case- by-case basis, considering the relevant constitutional provision and its application to the conditions of the matter.[146] Thus, the Court said that the South African government has the obligation to enforce the right to access treatment, and take the necessary legislative procedures to ensure accessibility of ARV medications.[147]Therefore, any policy that refuses refugees a transplant operation and even dialysis treatment is discriminatory and unconstitutional.

In *Minister of Health and Others v Treatment Action Campaign and Others*[148] the Court, referring to the *Grootboom* case, concluded that it is clear that s 26 does not expect more of the state than is achievable within its available resources, and that the State is not required to go beyond available resources or to realise the rights directly.[149] The Court further observed that any prohibition must be consistent with the Bill of Rights and must not amount to unlawful discrimination or impact negatively on dignity.[150] In the context of the *Soobramoney* case, regulating access to health care services is legitimate and is a necessity as the constitutional right cannot overshadow the reality of a scarcity of resources.[151]

It is clear that South Africa has taken adequate legislative measures to protect and promote the refugees right to access health care services as required under Art 2(1) of the ICESCR and the South African Constitution. However legislative measures are just one of the measures expected

[145]*Government of the Republic of South Africa and Others v Grootboom andOthers*(2000) 19 SA 46 (BCLR).
[146]*Government of the Republic of South Africa and Others v Grootboom and Others* (2000) 19 SA para 25 (BCLR).
[147]*Government of the Republic of South Africa and Others v Grootboom andOthers* (2000) 19 SA para 78 (BCLR).
[148]*Minister of Health and Others v Treatment Action Campaign and* Others (2002) 15 SA (BCLR).
[149] The Consitution of South Africa, 1966 Section 26.
[150]*Khosa and Others v Minister of Social Development and Others, Mahlaule and Another v Minister of Social Development* (2004) ZACC 11 SA (CC).
[151]*Soobramoney v Minister of Health Kwazulu-Natal* (1997) ZACC 17 SA (CC).

to be taken by States under the ICSER and the Constitution, bearing in mind that all Constitutional obligations must be performed diligently and without delay.[152]

3.5 Conclusion

As this chapter has demonstrated, the South Africa Government and judiciary have been reluctant to extend the important human right to health to refugees who are infected with HIV/AIDS. Creative judicial analysis, with regard to the right to health for refugees has been absent in South Africa. Such denial will continue to cast doubt on South Africa's commitment to the protection of socioeconomic rights in spite of its record.

Consideration should be given to eradicating the obstacles that refugees confront in the procurement of ARV care in South Africa. The hostile arrogances of xenophobic health care professionals towards refugees, the government's lack of authority in tackling the matter, the resulting effects and the common need for health care resources, show a clash in the common goal among all actors involved to fight HIV/AIDS.

The next chapter seeks to explore the same discussion on access to health for refugees within international framework but in the context of Uganda. This aims to show that even where epidemics have distinct gestations, national and international framework may be used as a tool to empower the HIV/AIDS movement.

[152]Section 237 of the constitution of South Africa.

CHAPTER 4

ACCESS TO HEALTH FOR REFUGEES AND THE INTERNATIONAL FRAMEWORK IN UGANDA

4.1 Introduction

This chapter will begin by setting out the current status of the right to health framework in Uganda specifically in the context of HIV. This Chapter will demonstrate the emergent prevalence of HIV within the camps in Uganda and will show how Government guidelines are inadequate to confront the problem.

4.2 The Status of the Right to Health in Uganda

Uganda is party to international and regional human rights instruments that explain the right to access health. The Constitution stipulates rights and freedoms, which are explicitly stated in the Bill of Rights, which 'shall not be viewed as rejecting others not explicitly cited such as the right to access health.'[153] It can therefore be said that the right to access health, although not specially stated, is officially recognised and can be applied in a competent court.[154] The right can also be kept throughout a creative interpretation of other constitutionally recognised rights such as the right to life. Uganda has undertaken the duty to give effect in its territory to the international human rights obligations specified in those instruments.[155] The state has a liberty of means to give effect to that duty, but whatever means it chooses, they must be adequate to ensure fulfilment of the rights recognised in those treaties.[156]

In Chapter two we have seen that the responsibility, or rather, the obligation to guarantee that all individuals enjoy the rights and freedoms guaranteed under the various human rights instruments lies primarily on the State. Refugees, owing to their specific circumstances, need protection from States other than their own. It is, however not automatic that a refugee will be granted protection by another State, despite the concept of asylum being referred to as a humanitarian act. It is to fill

[153] Art 50 of the Constitution of Uganda .
[154] Art 22(1) of ICESCR.
[155] Art.26, Vienna Convention on the Law of Treaties (VCLT) (1969) UN.Doc.A/CONF.39/27.
[156] CESCR, General Comment 9: The Domestic Application of the Covenant (1998) UN.Doc.E/C.12/1998/24, para 7.

in this protection void that international refugee law comes into play to ensure that a State does indeed accord a refugee the required protection.

4.2.1 Refugee Act

There is an increasing evidence of a link between violence against women and the process of armed conflict in Uganda. For example the flow of refugees across borders which affects countries whether they are part of the conflict or not.[157] In this regard, Uganda has an obligation to protect women refugees from all forms of violence and to ensure that women who are subjected to such violence have full access to the Ugandan legal system as clearly provided as follows. Art 11(3) of the Women's Protocol provides that 'State Parties are required to undertake to protect asylum seeking women, refugees, returnees and internally displaced persons, including access to health against all forms of violence, rape and other forms of sexual exploitation.'[158]

Uganda has also ratified the International Convention Relating to the Status of Refugees (ICRSR) 1951[159] and the Protocol Relating to the Status of Refugees 1969.[160] Although there is Ugandan legislation called the Refugee Act 2006, the Act made new provisions for matters relating to refugees in line with the 1951 Convention Relating to the Status of Refugees and other international obligations of Uganda relating to the status of refugees.[161] However studies have indicated that refugees are faced with problems such as inadequate health provision.[162]

Consequently, it does not exist any specific stipulation for the right to access health in the considerable Bill of Rights provision of the Ugandan Constitution. Therefore, since the government of their home country no longer protects the basic rights of refugees, the international community assumes the responsibility of ensuring that the rights of refugees are

[157] the Preamble of the Protocol relating to the Establishment of the Peace and Security Council of the African Union (adopted in Durban, South Africa, July 2002 and entered into force in December 2003), where member states are concerned 'by the fact that conflicts have forced millions of our people, including women and children, into a drifting life as refugees and internally displaced persons, deprived of their means of livelihood, human dignity and hope' (PSC Protocol).

[158] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.

[159] '1951 Convention Relating to the Status of Refugees' available at *www.unhcr.org/3b66c2aa10.pdf* [accessed on 16 October 2014].

[160] '1969 Protocol Relating to the Status of Refugees ' available at *www.unhcr.org/3b66c2aa10.pdf* [accessed on 16 October 2014].

[161] 'Uganda Act 2006' available at *http://urban-refugees.org/kampala/* [accessed on 16 October 2014].

[162] Mulumba D &Olema W 'Policy Analysis Report: Mapping Migration in Uganda' (2009)*http://www.immis.org/wp-content/uploads/2010/05/Policy-Analysis-Report-Uganda.pdf* [accessed on 17 October 2014].

respected. The conclusion of the United Nations High Commissariat of Refugees (UNHCR) Executive Committee (Excom) stipulates that the most important protection for refugees in the international human rights law is the principle of non-discrimination which guarantees that refugees, even though they are not citizens of the asylum country, are entitled to the same fundamental rights and freedoms (as contained in e.g. the UDHR and ICESCR) as citizens of that country.[163]

The relative success with which Uganda has been able to establish the essential framework for supplying access to HIV treatment in comparison to South Africa's disastrous record, may thus not only be situated in the constitutional protection or absence thereof. Several other elements and role players have been important in the evolution towards the existing condition concerning access to HIV drugs in Uganda and South Africa

4.2.2 The Link between International Human Rights Law and Refugee Law

Art 23 of the Convention on the Status of Refugees 1951 states:

> 'Contracting States shall accord to refugees lawfully staying in their territory the same treatment with respect to public relief and assistance as is accorded to their nationals, including medical health care.'[164]

Humanitarian law offers a vital complement to this, as shown by the 1949 Geneva Conventions and their additional Protocols, which apply to non-combatants, such as refugees, which advocate their protection against such atrocities as rape and indecent assault.[165] This shows the obligation to provide refugees with the same rights and assistance as are made available to nationals of a host State. Unfortunately, this is only occasionally the case, and worse still, apart from being denied equal access, the basic human rights of refugees are often disregarded by host States. This is problematic because human rights and HIV/AIDS are intrinsically linked. A disregard for basic human rights increases the prevalence and worsens the impact of HIV/AIDS; as such it is a

[163]Although excom conclusions are not legally binding on state in the same way as treaties, they are widely recognised as being the view of the international community and are persuasive
[164]'Article 23 of the Convention Relating to the Status of Refugees 1951' available at *www.unhcr.org/3b66c2aa10.pdf* [accessed 16 October 2014].
[165]'Roberts B HIV/AIDS, Conflict and Forced Migration' (2004) 4*http://www.forcedmigration.org/research-resources/expert-guides/hiv-aids-conflict-and-forced-migration/fmo036.pdf*[accessed on 17 August 2014].

useful framework for understanding and addressing the vulnerabilities of refugees because it helps address societal and contextual factors that determine vulnerability.[166]

4.2.3 Relations between International, Regional and National Laws Regarding Refugees' Rights

The Universal Declaration, regarded as part of international customary law[167] and therefore binding on all States, recognised the right to health not only as a right to health care but also to the underlying determinants of health, such as, food or social services.[168] The right of women not to be discriminated against with regard to access to health care has also been recognised in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW),[169] ratified by Uganda in 1980. The Committee on CEDAW imposed on States the obligation to guarantee timely, affordable and acceptable access to health care.[170] The Convention of the Rights of the Child (CRC), ratified by Uganda in 1996, also protects the right to health of children.[171] According to the Committee on CRC, States should provide ARVs to pregnant women and their partners, as well as children, on the basis of non-discrimination.[172]

In addition, States Parties must guarantee the incorporation of HIV/AIDS and child rights issues in programmes dealing with children victims of abuse.[173] The right to health is also recognised in the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), ratified by Uganda in 1980.[174] The Committee on the Elimination of All Forms of Racial

[166]'Roberts B HIV/AIDS, Conflict and Forced Migration' (2004) 4*http://www.forcedmigration.org/research-resources/expert-guides/hiv-aids-conflict-and-forced-migration/fmo036.pdf*[accessed on 17 August 2014].
[167]Gostin L 'Public health, ethics and human rights: a tribute to the late Jonathan Mann' (2001) 29 *Journal of Law, Medicine and Ethics* 121.
[168]Universal Declaration of Human Rights, General Assembly Resolution 217A (III), (1948) UN Doc A/810.art.25 (1).
[169]Convention on the Elimination of all Forms of Discrimination Against Women, General Assembly Resolution 34/180,1979 UN Doc. A/34/36.Art11(1)(f), 12, 14(2)(b).
[170] General Recommendation (GR) 24: 'Art.12: Women and Health', (1999) UN.Doc.A/54//38 paras.21-22.
[171]Convention on the Rights of the Child, General Assembly Resolution 44/25 (XLIV), (1989) UN DocA/44/49, art 6, 24.
[172]Committee on the Rights of the Child, General Comment 3: 'HIV/AIDS and the rights of the child' (2003) UN Doc CRC/GC/2003/1,para 23.
[173] Committee on the Rights of the Child, General Comment 3: "HIV/AIDS and the rights of the child" (2003) UN Doc CRC/GC/2003/1, para.34.
[174] International Convention on the Elimination of All Forms of Racial Discrimination, General Assembly Resolution 2106 (XX) (1965) art.5.

Discrimination (CERD) expressed its concerns with regard to the rapid spread of HIV/AIDS among marginalised groups of refugees.[175]

At regional level, the African Charter on Human and Peoples' Rights (ACHPR),[176] ratified by Uganda in 1986,[177] protects the right to health in its Art 16. The ACHPR provide an adequate forum for the enforcement of this right, since it does not limit its realisation in any sense[178] and recognises the interdependence of all human rights.[179] Furthermore, the African Commission of Human and Peoples' Rights (African Commission) can draw inspiration from several sources of international law when deciding on complaints.[180] The Commission has already stressed the problems that refugees with HIV face in accessing treatment as one of the major obstacles in realising their right to health.[181] The African Charter on the Rights and Welfare of the Child (ACRWC), ratified by Uganda in 1994, emphasises the right to access primary health care.[182] With the creation of the African Court on Human and Peoples' Rights, the protection of the right to health could be obeyed through binding judgments.[183]

Besides, since the jurisdictional scope of the Court will also include other human rights instruments ratified by the country,[184] it could become a complaint mechanism for those human rights instruments that do not have it, such as, the ICESCR or the CRC. Another major avenue presenting a big challenge in the fight against HIV/AIDS is sexual violence during armed conflict.

[175]Committee on the Elimination of all forms of Racial Discrimination, Concluding observations on Uganda, (2003) UN Doc A/58/18 para 280.
[176]The African Charter on Human and Peoples Rights (1982) OAU Doc. CAB/LEG/67/3/Rev.5.
[177]*http://www.achpr.org/english/_doc_target/documentation.html?../ratifications/ratification_charter_en.pdf* [accessed 17 October 2014].
[178]Odinkalu A 'Implementing Economic, Social and Cultural Rights under the African Charter' in M Shaw *et al* eds*The African Charter of Human and People's Rights: The System in Practice* (2002) 357.
[179]Art.8 of African Commission on Human and Peoples Rights (ACHPR).
[180]Art.60 ACHPR.
[181]Final communiqué of the 29th ordinary session of the African Commission of Human and Peoples', para.7.
[182]The African Charter on the Rights and Welfare of the Child (1990) OAU Doc.CAB/LEG/24.9/49.
[183]The Protocol to the African Charter on the Establishment of an African Court became into force in 2004, but the Court is not yet operational. Uganda ratified the Protocol in 2001para.7.
[184]Art.3, 7 of ACHPR.

4.3 Constitutional Framework of Uganda

Unlike South Africa, Uganda gives minimal care to socio-economic rights in its Constitution.[185] Exception is: the right to a clean and healthy environment[186] which is recognised in the Bill of Rights.

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. 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 Ugandans to social justice and economic development' (Objective XIV) and for 'basic medical services' to the population (Objective XX). Other relevant provisions are those providing for equality under the law, and freedom from discrimination in Art 21.[187]

International human rights law emphasises the implementation of administrative, legislative, executive and judicial procedures for the realisation of the right to access health.[188] The ESCR Committee acknowledges that every country has degree of discretion in evaluating the opposite feasible procedures for realising the right to health in general and the right to health care in particular.[189] In Uganda, there is no legislation that explicitly deals with the right to health and its constituents, such as the right to health care with regard to HIV issues. It is certainly regrettable that none of the international and regional human rights instruments that recognise the right to access health care have been immediately integrated into the national legal framework. Nevertheless, most of the problems regarding the promotion and protection of the right to access health in the HIV context are protected under policies, which are significant because they prescribe what level of health care facility is assured. They also guarantee what types of goods and services will be supplied.[190] The policy system also facilitates spelling out how priorities may be determined between competing demands and where to concentrate supplies. Uganda has

[185]The Constitution of the Republic of Uganda (1995).
[186] Art 39 of the Constitution of Uganda.
[187]Kuper J 'Law as a Tool: The Challenge of HIV/AIDS in Uganda' (2005) 69 *Working Paper: Crisis States Research Centre* 16.
[188]Art 2(2) of ICESCR.
[189]Committee on Economic, Social and Cultural Rights, General Comment 14, The right to the highest attainable standard of health, 2000 U.N. Doc. E/C.12/2000/4 (2000) para 53.
[190]Mubangizi J 'The Right to Health Care in the Specific Context of access to HIV/AIDS Medicines: What can South Africa and Uganda learn from each other?'(2010) 10 *African Human Rights Law Journal* 122.

a complex policy system, critical for the motivation of the right to health care in HIV/AIDS context. The policy system, developed in cooperation with civil society and contributors, recognises the influence of poverty on access to health care facilities, goods and services.[191] Although the judiciary in South Africa has been quietly innovative in the subject of the right of access to health care for persons living with HIV, courts in Uganda have not yet expessed themselves on this matter.[192]

The right of access to essential treatment is recognised in various human rights instruments. According to the CESCR, this right forms part of the core content of the right to health, which States must satisfy, whatever their stage of economic development. In addition, access to essential treatment is crucial for the realisation of many other rights recognised in the international instruments of relevance to Uganda. These international instruments impose on Uganda the obligations to respect, protect and fulfil the right in question, irrespective of the means chosen by the country to implement them at the national level. Equally, Non-State actors have also undertaken obligations with regard to this right at the international level and their interaction in the realisation of this right would need to be assessed.

Uganda has become party to most of the major international human rights treaties whether global or regional, general or explicitly 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.[193]

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

[191]'The Fight against HIV/AIDS in Uganda' (2006) available at *http://unpan1.un.org/intradoc/groups/public/documents/un/unpan023881.pdf* [accessed on 16 October 2014].
[192]Mubangizi J 'The Right to Health Care in the Specific Context of Access to HIV/AIDS Medicines: What can South Africa and Uganda learn from each other?'(2010) 10 *African Human Rights Law Journal* 127.
[193]Kuper J 'Law as a Tool: The Challenge of HIV/AIDS in Uganda' (2005) 69 *Working Paper: Crisis States Research Centre* 15.

4.3.1 Challenges faced by Refugees Regarding Access to Health in the Context of HIV in Uganda

Uganda is a landlocked country situated in the eastern part of Africa and is one of the countries of the Great Lakes region,[194] Which has been overwhelmed by a number of armed conflicts with attendant serious and gross human rights violations. As such there is a great number of refugees in the region and by virtue of its position amidst conflict-prone countries, Uganda has been a State of asylum for many refugees.[195]

Helton identifies some aspects of refugee protection, in practical language, as including: fair and non-discriminatory status determination in a country of protection, provision of protection and respect for the fundamental individual rights of refugees, especially those held in camps following flight from persecution and respect for the principle of *non-refoulement*.[196] He sums it all up by saying that, 'in a fundamental sense, protection means to ensure the enjoyment of basic human rights.'

However, Knipe and Rector affirm that HIV/AIDS and migration are two of the greatest social problems confronting the world nowadays.[197] Persons with HIV/AIDS and migrants, both faced marginalisation from resources and absence of respect for human rights.[198]

In Uganda, supervision at antenatal clinics is much less important since most of the surveillance sites are in urban areas whilst most the refugees live in rural areas and have limited access to health care services.[199] On the issue of integration in health care services, refugees point out, the reductions in the quality of services and lack of access to certain services due to the transfer in an

[194]The Great Lakes region in Africa comprises of the following countries: Burundi, Democratic Republic of Congo (DRC), Kenya, Rwanda, Tanzania and Uganda.
[195]Lomo at al 'The Phenomenon of Forced Migration in Uganda: An Overview of Policy and Practice in and Historical Context' (2001) 1 *Refugee Law Project Working Paper Refugee Law Project*3.
[196]Helton A 'What is Refugee Protection? A Question Revisited' in Steiner, Gibney & Loescher eds *Problems of Protection: The UNHCR, Refugees and Human Rights*(2003)Routledge, New York and London 23.
[197]Knipe M & Rector R *Crossing Borders: Migration, Ethnicity and AIDS* (1996)London, Taylor & Francis.
[198]Williamson K 'AIDS, Gender and Refugee Protection Framework' (2004) 19 *Working Paper :Refugee Studies Centre* 11.
[199]Allen T &Heald S 'HIV/AIDS Policy in Africa: What has Worked in Uganda and What has Failed in Botswana?'(2004) 16 *Journal of International Development* 1142.

urban area. Diminished provisions for refugees included lack of transport to health centres or hospitals for the very sick and lack of availability of drugs at the health centres.[200]

However, the demand for health care within the public health care system far outweighs supply. Health clinics and hospitals in Uganda not only care for patients from within the city but are also under immense pressure from refugees. In this context, many refugees and citizens experience similar problems in gaining access to the health care system.[201] Examples of common problems are a lack of prescription drugs and extensive waiting times in hospitals and doctors' offices.[202] Due to a general lack of resources, the public hospital must charge all patients for more expensive services and drugs, with the result that refugees do not receive the treatment they need.[203] Access for everyone, regardless of nationality depends on their personal financial resources.

As to particular problems faced by refugees, language barriers were cited as the main factor impeding refugees' access to health services. In fact, it has been acknowledged that language barriers limit refugees' access to services. As a result of this situation, many refugees stated that they had to use their own methods for raising the cash needed for medical treatment. A number of refugees obtained assistance from churches or religious leaders, while others had the means to pay for private treatment at local clinics. In some cases, refugees hoped to raise money from their respective nationality groups to pay for the treatment needed. However, some refugees had no choice but to let diseases and injuries go untreated, having no way to pay for the required treatment.[204]

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[200]Meyer S 'The Refugee Aid and Development' Approach in Uganda: Empowerment and self-Reliance of Refugees in practice' (2006) 131 *New Issues in Refugee Research* 37.
[201]'A Drop in the Ocean: Assistance and Protection for Forced Migrants in Kampala' (2005) 16 *Refugee Law Project Working Paper* 34 available at *http://allafrica.com/download/resource/main/main/idatcs/00010679:3efa2899f92e96d299b010e44ead45d9.pdf* [accessed on 16 October 2014].
[202]'A Drop in the Ocean: Assistance and Protection for Forced Migrants in Kampala' (2005) 16 *Refugee Law Project Working Paper* 34 available at *http://allafrica.com/download/resource/main/main/idatcs/00010679:3efa2899f92e96d299b010e44ead45d9.pdf* [accessed on 16 October 2014].
[203]'A Drop in the Ocean: Assistance and Protection for Forced Migrants in Kampala' (2005) 16 *Refugee Law Project Working Paper* 34 available at *http://allafrica.com/download/resource/main/main/idatcs/00010679:3efa2899f92e96d299b010e44ead45d9.pdf* [accessed on 16 October 2014].
[204] 'A Drop in the Ocean: Assistance and Protection for Forced Migrants in Kampala' (2005) 16 *Refugee Law Project Working Paper* 34 available at

However, in Uganda there is limited access to maternal health care generally and emergency obstetric care (EmOC) in particular. This is especially so for vulnerable individuals such as refugees in need of EmOC. The judiciary has a fundamental responsibility to protect socio-economic rights such as access to EmOC. Courts have the legitimacy and competence to adjudicate socio-economic rights. The exercise of judicial power through the administration of justice includes issues of social justice, such as access to EmOC.

The courts in Uganda may have to consider the `practical measures' undertaken by the State to ensure that refugees have access to health care, including medical services such as EmOC. The courts can benefit from the jurisprudence of treaty bodies and case law from other jurisdictions that have considered related provisions.[205] In cases involving violations of human rights, the courts must be alive to international human rights instruments and apply them to a given case when there is no inconsistency between the international norms and the domestic legal order. It can be relied on to advance the cause for access to EmOC in Uganda.

In any case, not every pregnant woman needs EmOC since most women deliver normally. When challenged in court, the government of Uganda has a burden to demonstrate that its decisions were taken rationally and in good faith. However, litigation requires that human rights activists adduce necessary evidence to show that the Sstate is capable of meeting its immediate obligation to ensure access to EmOC.

4.3.2 Inadequate Law, Relevant to the Ugandan HIV/AIDS Strategy

Thus, though Uganda does not have legislation especially concerning HIV/AIDS, it has a body of behaviour-related law that is very pertinent to individual and societal norms of conduct that affect the HIV/AIDS trajectory in the country. However, there remain problems with both the

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http://allafrica.com/download/resource/main/main/idatcs/00010679:3efa2899f92e96d299b010e44ead45d9.pdf [accessed on 16 October 2014].

[205]Generally, the position in Uganda is that international law becomes part of domestic law only where it has been specifically incorporated. However, in recent years, courts have increasingly referred to international law and case law from other jurisdictions, especially where there is an ambiguity or lack of a specific provision on the matter. Example *Tinyefuza v Attorney-General*, Constitutional Petition 1/1997; *OnyangoObbo& Another v Attorney-General*, Const App 2/2002.

content of the law and the fact that in Uganda law generally is not accessible and/or is prone to institutional problems.[206]

In relation to HIV/AIDS and refugees, three inter-related issues need to be looked at in the alleviation of discrimination: the wider context of international inequality between States and the declining commitment of richer States to engage with the problems of poorer States; the commitment of relief agencies to recognise long-term rights as well as meeting short-term needs in emergency situations and the empowerment of marginalised groups, particularly women, within refugees communities.[207]

As stated above, migration and HIV/AIDS characterise two issues within the same continuum of social marginalisation, inequality and lack of human rights. Refugees characterises the extreme of this continuum, then the failure to address sufficiently the further spread of HIV/AIDS within refugees situation is as indicative of the acceptance of selective human wastage as it is indicative of the difficulties in changing the social environment and human behaviour.[208] Instead, HIV/AIDS prevention strategies demand to take these in to account and incorporate solutions to these problems as part of the initial package of emergency response.[209]

Therefore there is a problem in Uganda concerning lack of law, or inadequate law, related to the HIV/AIDS pandemic. It is of note that despite the many international treaties ratified and the provisions of the Constitution, certain groups that are mostly affected by HIV/AIDS, such as refugee women and children, lack the legal tools that could make them less vulnerable. This is either because current laws are not well applied, and/or there are gaps or inadequate provisions in the pertinent law.[210]

The failure of HIV/AIDS prevention programmes to address sufficiently the needs of women and other marginalised, vulnerable groups can be seen as a denial of their rights to health and life and characterises a profound expression of the social value attributed to them.

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[206]Kuper J'Law as a Tool: The Challenge of HIV/AIDS in Uganda' (2005) 69 *Working Paper: Crisis States Research Centre* 18.
[207]Williamson K 'AIDS, Gender and the Refugee Protection Framework' (2004) 19 *Working Paper: Refugees Studies Centre* 21.
[208]Carballo & Siem '*Migration, Migration Policy and AIDS'* in Knipe M & Rector R eds Crossing Borders: Migration, Ethnicity and eds (1996) Taylor & Francis, Exeter 44.
[209]Williamson K (2004) 11.
[210]Kuper J (2005) 20.

4.4 Concluding Observations of Treaty Monitoring Bodies Relating to the Issues Discussed in the two Countries in Question

It may be said that Uganda has a relatively more developped policy framework than South Africa in the particular context of HIV/AIDS. Nevertheless, policies are not lawfully binding: They merely have political obligations. Therefore, Uganda should, like South Africa, plainly recognise the right to access health in the Constitution, which would eliminate any uncertainties about the justiciability of the right.[211] It should be noticed, however, that it is not adequate to simply recognise the right in the Constitution. The ESCR Committee orders countries to consider implementing a domestic framework law to give effect to the right.[212] To this conclusion, there is a crucial demand for health legislation that clearly requires the government to guarantee adequate, affordable and accessible health care, including anti-retroviral treatment to its individuals who need special care to the poor and vulnerable, such as refugees.[213] The regulations of every country should include provisions on periodically monitoring and evaluation of performance of relevant health sectors.

4.5 Conclusion

It is at the intersection of refugees' access health care in HIV/AIDS context where the problem of refugees' health remains and where such individuals merit extra treatment and support. The growth in the incidence of HIV/AIDS is a matter that is having a damaging effect in Uganda. The statistics emphasised above show the importance of confronting the infection in this country and the necessity to accord access to health to as many individuals as possible. However refugees with HIV/AIDS, whether in the country lawfully or not are, therefore in need of focused attention not preventive, unfair Government policies. Failure to do so will result in generating a stigmatised and marginalised group of unlawful refugees having a potentially fatal infection.

Indeed, the legislative framework in place is outdated and totally inadequate to tackle the epidemic. The measures at policy level do not offer a structured response to the problem and

[211]C Heyns & F Viljoen 'The impact of the United Nations treaties on the domestic level' (2001) 23 *Human Rights Quarterly* 483.
[212]Committee on Economic, Social and Cultural Rights, General Comment 14, The Right to the Highest Attainable Standard of Health, para 53.
[213]Mubangizi J 'The Right to Health Care in the Specific Context of Access to HIV/AIDS Medicines: What can South Africa and Uganda learn from each other?'(2010) 10 *African Human Rights Law Journal* 130.

they do not recognise the resources available and needed for achieving the objectives. Furthermore, the resources mobilised at national level are inadequate and those obtained from the donor community do not seem to be handled in the most effective way. The justiciability of the right to access essential treatment encounters also some obstacles, a result of its weak recognition in the Constitution, the conservative approach taken by some of the Courts, and the lack of activism among civil society. On the other hand, the response of the government seems to be short of the same political as shown with regard to HIV/AIDS prevention, and this shows another reality behind the apparent success story of Uganda with regard to HIV/AIDS.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions

Increasing rates of migration and the HIV/AIDS epidemic have intensified the necessity to study the link between the human right to health and the necessities of infected refugees. This paper set out to study the access to care for HIV/AIDS sufferers in the context of refugees in South Africa and Uganda. To do this it has studied the failing direction which South Africa and Uganda have taken as regards the right to health of refugees. The government and judiciary have regonised the fundamental human right to health for refugees who have HIV/AIDS.

The governments of South Africa and Uganda are breaching the refugees right to access health care to the highest possible level as provided by ICESCR. Poor refugees are being denied hospital care. Refugees must be given the same health care rights as citizens. A policy prohibiting or barring refugees from receiving certain health care is unconstitutional. When considering the curtailment of a right, such right must be considered as part of a basket of socio-economic rights in the context of available resources.

Uganda and South Africa have implemented different methods to the protection of the right to access treatment for refugees in general and the right of access to HIV/AIDS drugs in particular. While these methods have caused various and disparate effects, South Africa and Uganda should be held accountable for the infringement of those health care rights though in various degrees. Nonetheless, it is evident that Uganda and South Africa have a lot to learn from each other. As South Africa, Uganda has to provide more respect for the right to health care in its Constitution. Furthermore, there is also an urgent requirement for a legislative framework for the protection of health care rights for refugees and particularly the right to HIV/AIDS drugs as the present policy framework alone is not sufficient. A higher level of constitutional protection and a complex legislative framework will permit Ugandan courts to play a more significant role in addressing problems of access to health care through interpretation and process.

As has previously been said, many of the rights and key notions within the instruments examined are related to the protection of the right of refugees to access treatment from exposure to HIV, particularly for refugees regarding the right to health is in respect of information and education to prevent HIV. If the relevant provisions are efficiently applied, they can substantially reduce the marginalisation of refugees in regard to access to treatment and consequently translate into regional instruments and national HIV laws, programmes and policies, thereby mainstreaming the specific needs of refugees to access treatment and more specifically refugees' in relation to the right to health.

It is therefore recommended that regional and national provisions concerning refugees' access to health and HIV in South Africa and Uganda should make provision for the creation of methods to guarantee that public awareness programmes on HIV are accessible to all refugees no matter their nature or category of origin. This can best be achieved by making such regional instruments, plans, policies and legislation more particular both with regard to features of the region, and more significantly with regard to the national requirements. This requires guaranteeing that legal instruments and policies tackle the peculiar challenges confronted by so many groups or types seeking of access to health in order to attain holistic and more particular forms of protection. In addition, this promotes particular responses to the various challenges, whether physical, mental or psychological, to mention a few.

There is an urgent need for African regional instruments as well as national strategies to recognise the complexities of the notion of access to health for refugees and ensure that as much attention is paid to addressing the peculiar needs of this vulnerable group. With respect to refugees in respect of access to health, the following recommendations are proposed in order to ensure equal access to services and information on HIV for refugees.

5.2 Recommendations

Consideration should be given to eradicating the barriers that refugees face in access to treatment in South Africa and Uganda. Additionally, national legislation should be implemented by imposing on the government the obligation to make every effort to access to essential treatment for refugees in need. The government should be obliged to put mechanisms in place that will provide the geographic accessibility of the drugs, mostly in neglected areas. In addition, criteria

should be developed to determine the category of refugees that could have access to free drugs, subsidised drugs or pay drugs. The government should be made liable to seek a rapid and sustainable solution for the provision of essential treatment to refugees living in conflict areas. The law should also impose on the government the immediate obligation to inform the population of the possibility of obtaining essential treatment and the benefits ART brings to refugees. The possibility of challenging the implementation of the law before the courts should also be foreseen.

5.2. 1 Recommendations Regarding South Africa

HIV/AIDS and the right to health:

- To eradicate discriminatory barriers on access to prevention, treatment and care for HIV;
- Guarantee that all government departments, including the Department of Transport, are concerned in developing and implementing plans aimed at reducing physical and cost barriers to access to HIV-related health services in rural areas;
- To facilitate the collection of data, disaggregated on the basis of gender and other groups identified as facing discrimination, to assist identification of discriminatory factors affecting a person's ability to access and remain on treatment.

Refugee rights:

- To fulfil its international, regional and domestic legal obligations to protect the rights of refugees, without distinction as to national origin
- To guarantee, in collaboration with civil society, implementation of legislation, plans and directives which growth the prevention, investigation and prosecution of property destruction and crimes of violence against refugees;
- To ensure that no actions, direct or indirect, lead to a violation of the principle of non-refoulement.

5.2.2 Recommendations Regarding Uganda

In Uganda, there was agreement that there needs to be further steps taken in order to better integrate the two research fields for access to health in the context of 'refugees' and 'HIV/AIDS.' This can be done by building perceptive in both research fields and by creating new understanding, exploring the interface between the two types of research. Also, the need for high quality national, regional and international research collaboration around these themes was emphasised. The recommendations that transpired from the workshop emphasised the importance of focusing on the following areas for research in the field of population mobility in access to health and HIV/AIDS: (i) Impact of refugees on rural communities; (ii) The role of government; (iii) Evaluation of HIV interventions in the context of refugees; (iv) Different levels of causation of HIV transmission; (v) Role of refugees' mobility in HIV epidemiology; (vi) Health worker refugees.

Additionally, national legislation should be implemented imposing on the government the obligation to make every effort to use all available resources, including those of the international community, in an effort to fulfil, as a matter of priority, the right to health for the population in need (refugees). The government should be required to put procedures in place that will provide the environmental accessibility to the drugs, mainly in neglected areas. In addition, criteria should be developed to regulate the categories of refugees that could have access to free drugs, subsidised drugs or pay drugs.

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