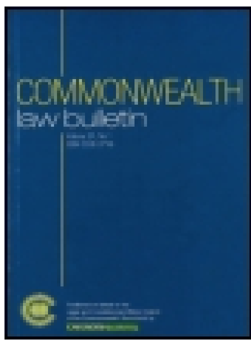

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ISSN: 0305-0718 (Print) 1750-5976 (Online) Journal homepage: https://www.tandfonline.com/loi/rclb20

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To cite this article: Tenywa Aloysius Malagala (2009) Is there a need for a human rights based Approach to health in Uganda?, Commonwealth Law Bulletin, 35:3, 463-496, DOI: 10.1080/03050710903112982

To link to this article: https://doi.org/10.1080/03050710903112982

Published online: 18 Sep 2009.

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Commonwealth Law Bulletin
Vol. 35, No. 3, September 2009, 463–496

Routledge
Taylor & Francis Group

Is there a need for a human rights based Approach to health in Uganda?

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Health is a fundamental human right that has great impact on the full realisation of other human rights including economic rights. In order to promote the health of the people and to increase the productivity of the population in a more sustainable way, there is need to do more than simply providing medical facilities and preventing and treating ailments. There is a need to address the injustices that occur in the relationships between the health service providers and the patients. Crucially, there is a need to address the stigma and discrimination, and all other health-related issues that hinder the full realisation of the right to health of vulnerable members of society in Uganda. A human rights-based approach to health is perhaps more likely to be effective, inclusive, equitable, sustainable and efficient in addressing such obstacles than other approaches. This approach calls for: a) recognition of the national and international human rights framework; b) empowerment and active participation of all stakeholders in all matters pertaining to their health; c) accountability; d) equality and non-discrimination; and e) progressive realisation of the right to health. Thus, human rights principles must guide the analysis, design, implementation, monitoring and evaluation of health promotion programmes in Uganda.

1. Introduction

The right to health in Uganda is not fully realised despite over two decades of serious government intervention. From 1986 to 1993 the current Ugandan government under President Yoweri Museveni began a period of rehabilitation and reconstruction of the country in many aspects, including the health sector. Many multilateral and bilateral donors increased their levels of aid to support the rehabilitation effort. Although improvement of healthcare service delivery to all people was a key element in many aid programmes, this was not the main concern of the government. It concentrated instead on hospital rehabilitation as reflected in its national health plan at that time.[1] No wonder, therefore, that numerous vertical programmes were created by various donors to fill the policy vacuum. For instance, the United Nations Children Fund (UNICEF) had child survival programmes; United States Agency for International Development (USAID) had family planning; Danish International Development Agency (DANIDA), essential drugs; and the World Bank, physical

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[1] J Macrae, *Aiding Recovery: The Crisis of Aid in Chronic Political Emergencies* (Zed Books, London 2001).

ISSN 0305-0718 print/ISSN 1750-5976 online
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DOI: 10.1080/03050710903112982
http://www.informaworld.com

rehabilitation. At this stage health in Uganda was not treated from a human rights perspective either by government or by the donors. In fact, even though Uganda's Poverty Reduction Strategic Plan (PRSP) recognises health as key to poverty reduction, and thus contributes greatly to the growth and development of people and the country at large, the health sector does not apply a human rights-based approach to health, and all its policies are not fully pro-poor in the true sense of the word.

Generally, the healthcare services still need improvement, especially in remote areas due to understaffing, poor terms and conditions of work, and low salaries which are sometimes delayed. Trained staff concentrate in urban centres, but they lack supervision and as such their quality of service is not always up to standard.[2] Consequently, infant, child and maternal mortality rates are still high in Uganda. A case study by the Uganda Debt Network in 2003 revealed that infant mortality among the poor is 80% higher than among the non-poor,[3] and it remains high at the present time. The maternal mortality ratio stands at 506 deaths per 100,000 births.[4] In addition to the lack of qualified staff, there is a shortage of drugs, especially in rural remote areas. The poor, particularly women, are not able to access health facilities for emergency obstetric care (EmOC). Twinomugisha notes that 'access to EmOC [in Uganda] remains extremely low, at 5.1%, far below the United Nations recommended rate of 15%.'[5] Yet emergency obstetric care has the potential to reduce maternal mortality and morbidity.[6] Generally, the poor in rural districts have recorded little improvement in basic social and economic conditions. In many areas, particularly in the north where conflict continues, the essential facilities which support livelihoods have still not been restored.[7] Investment in social sectors such as education and health, have failed to improve the overall level of service delivery.[8]

Yet health is a fundamental human right closely related to the right to life[9] and necessary for the full realization of other human rights, including economic, social and cultural rights. Article 1 of the Universal Declaration of Human Rights (Universal

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[2]See UPPAP 11. See Uganda Participatory Poverty Assessment (PPA) II: Bugiri District Draft Report (July 2002), pp. 83–35 <www.finance.go.ug/docs/Bugiri%20District%20Report.pdf> accessed 14 July 2009.

[3]Uganda Debt Network, 'The Poverty Reduction Strategy Papers (PRSP) and Resource Allocation to the Health Sector in Uganda', Discussion Paper No 7 (April 2004) <http://www.eldis.org/static/Doc16789.htm> accessed 6 September 2008.

[4]See Ministry of Health (Uganda) Health Sector Strategic Plan (2006) 33.

[5]Kiromba Twinomugisha, 'Exploring Judicial Strategies to Protect the Right of Access' (2007) 7(2) African Human Rights Law Journal 283–306, at 284.

[6]See World Health Organisation, 'Using Human Rights for Maternal and Neonatal Health: A Tool for Strengthening Laws, Policies and Standards of Care' (2004). Paxton *et al* argue that health facilities should have basic and comprehensive EmOC services. The former include services such as administration of antibiotics, oxytocic drugs, removal of placenta manually, internal cleaning and assisted natural birth delivery, while the later involves ability to perform a caesarean section and blood transfusion. See A Paxton et al, 'The United Nations Process Indicators for Emergency Obstetric Care: Reflections based on a Decade of Experience' (2006) International Journal of Gynaecology and Obstetric 192–193.

[7]See UN Special Rapporteur on the Right to Health Report E/C.4/2006/48 Add 2 para 51.

[8]A. Kreimer et al, *Uganda Post/Conflict Reconstruction – Country Case Study* (World Bank, Washington 2000).

[9]See International Covenant on Civil and Political Rights (ICCPR) article 6, as interpreted by the Human Rights Committee General Comment No.6 (189).

Declaration) provides that 'all human beings are born free and equal in dignity and rights"; and Article 25(1) provides that 'Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and the necessary social services'. It follows, therefore, that every human person is entitled to be treated with dignity. Consequently, one of the attributes of a life of dignity that everyone aspires to is health, which 'is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.[10] The consideration of health as a human right empowers the rights holders to demand accountability from the obligation bearers.[11]

This article argues that in order to promote the right to health of all people, and to increase the productivity of the population in a more sustainable way,[12] there is a need to do more than just provide medical facilities and prevent and treat ailments. There is a need to address the injustices that may occur in the relationships between the health-service providers and the patients. There is a need to address the stigma and discrimination, and all other health-related issues that hinder the full realisation of the right to health of vulnerable members of society in Uganda, such as women, children, lepers and all the victims of neglected diseases. This could be done most efficiently by considering health through the prism of human rights as explained in the UN international human rights' system.

The article is divided into nine sections. Section 1 is the introduction and gives an overview of the problem. Section 2 lays down the legal foundation of the right to health as outlined by the national, international, and regional instruments. The section draws on the jurisprudence on the right to health and the teaching by the UN Special Rapporteur on the right to health. Section 3 outlines and explains Uganda's obligation concerning the right to health. Section 4 explains how Uganda can apply a human rights approach to health. Section 5 lays out what Uganda is doing and suggests what should be done. Section 6 outlines the need for the Ugandan government to work with civil society organisations (CSOs) in order to bring about the full realisation of the right to health and cites as an example the contribution of the Uganda National Health Users/Consumers' Organisation (UNHCO). Section 7 is about the contribution of multilateral organisation in the area of human rights in Uganda. Section 8 is on the way forward and, finally, Section 9 provides the conclusion.

2. The legal basis of the right to health

Uganda is signatory to a number of international and regional human rights instruments that give rise to the legal basis of the right to health. These instruments ought to guide Uganda in its legislation and policy on the right to health.

[10]See the Opening text of the WHO Constitution (1946).
[11]See F Stewart, 'Basic Needs: Strategies, Human Rights, and the Right to Development' (1989) 11 Human Rights Quarterly 347.
[12]Amartya Sen notes that 'good health and economic prosperity tend to support each other. Healthy people can more easily earn an income, and people with a higher income can more easily seek medical care, have better nutrition, and have the freedom to live healthier lives', cited here by Arif H Khan, See Arif H Khan, 'Health and human rights' *The Daily Star* (20 December 2007) <http://www.thedailystar.net/story.php?nid=16100> accessed 20 December 2007.

2.1 International human rights instruments on the right to health

These instruments lay particular importance on health as a human right for all people in general, and stress the 'unique position of women as mothers', in particular.[13] For instance, while the Universal Declaration of Human Rights guarantees all people the right to a standard of living and medical care,[14] it recommends special care and assistance to mothers.[15] The International Covenant on Economic, Social and Cultural Rights (CESCR, 1966), calls on all States Parties 'to recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.'[16] The Committee on Economic Social, and Cultural Rights (ESCR Committee) interpreted art 12(2) of CESCR to enumerate the actions that States have to take in order to improve child and maternal health services. Crucially, States have to ensure that health services are available, accessible, affordable, acceptable to all people, and that these services are of good quality.[17] States are to endeavour to remove any obstacle that hinders people from accessing healthcare. The right to health is also defended and protected by the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT).

The UN Convention on the Rights of the Child (CRC), enjoins States Parties, among others, to take appropriate measures to 'ensure the provision of necessary medical assistance and healthcare to all children with emphasis on development of primary healthcare.'[18] The International Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1979) protects the women's 'right to health and to safety in working conditions, including the safeguarding of the function of reproduction.'[19] It also prohibits 'discrimination against women in the field of healthcare in order to ensure, on a basis of equality of men and women, access to healthcare services, including those related to family planning.'[20] The International Convention on the Elimination of All Forms of Racial Discrimination (ICERD, 1965) promotes 'the right to public health, medical care, social security, and social services' for all people without exception.[21] And the International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families guarantees them 'the right to receive any medical care.'[22]

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[13]Kiromba Twinomugisha, 'Exploring Judicial Strategies to Protect the Right of Access' (2007) 7(2) African Human Rights Law Journal 283–306 at 287.
[14]Art 25(2) Universal Declaration.
[15]Art 25(1) Universal Declaration.
[16]Art 12 (1) CESCR.
[17]See ESCR Committee 'The right to highest attainable standard of health' General Comment No 14 (2000), EC/12/2000/4 para 14; ESCR Committee 'The Equal Right of Men and Women to Enjoyment of all Economic, Social, and Cultural Rights', General Comment No 16 (2005), E/C/12/2005/3 pqrq29.
[18]Art 24(b) CAT.
[19]Art 11 (1)(f) CEDAW.
[20]Art 12 (1) CEDAW.
[21]Art 5 (e)(iv) ICERD.
[22]Art 28 of International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families.

2.2 Regional human rights instruments on the right to health

A number of regional instruments protected the right to health. The African Charter on Human and People's Rights (African Charter) provides that every person has 'the right to enjoy the best attainable state of physical and mental health.'[23] Article 14 of the African Charter on the Rights and Welfare of the Child guarantees the right to health of children without discrimination.[24] While the Protocol to the African Charter on the Rights and Welfare of Women (2003) enjoins States to respect women's right to health.[25] The Abuja Declaration on HIV/AIDS, Tuberculosis and other related infectious diseases promotes the right to health. It specifically maintains that all the States Parties pledge to 'set a target of allocating at least 15% of their annual budget to the health sector.'[26] Other regional instruments which recognise the right to health, but to which Uganda is not a signatory, include the European Social Charter (1965)[27] and the Additional Protocol to the American Human Rights on the Area of Economic Social and Cultural Rights (1988).[28]

What then is the precise definition of the right to health? Is it the right to have access to free healthcare? Is it the right to be healthy? The right to health does not mean a right to be healthy, and, as such, no government or individual can be held accountable for the unhealthy condition of others who might become victims as a result of their personal choice of behaviour.[29] It is plausible to argue that the right to health is a human right to a functioning, effective, and integrated health system which encompasses healthcare and other determinants of health for all people without exception.[30] The promotion of health through provision of healthcare services to all people is therefore not an act of charity but an obligation on the part of the government.[31] In *Purohit and another v The Gambia*, the African Commission on Human and Peoples' Rights (The African Commission) broadly interpreted the right to health and held that this right refers to the 'right to health facilities, access to goods and services' by all the people.[32] The health facilities, goods and services promote the human dignity and the common good. In this context, healthcare and other determinants of health such as shelter, safe drinking water, and sanitation are more than a commodity in so far as they crucially safeguard human life and dignity for everyone.

When does the government violate the right to health of its people? What is the cause of this violation, a consequence of the actions of the government per se, or a

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[23]Art 16 (1) African Charter.
[24]Art 14 African Charter on the Rights and Welfare of the Child.
[25]Art 14.
[26]See OAU/SPS/ABUJA/3 para 26 <http://www.un.org/ga/aids/pdf/abuja_declaration.pdf> accessed 30 July 2008.
[27]Art 11 Revised.
[28]Art 10.
[29]Someone might decide to smoke and develop lung cancer in the end. One can not blame the government for such an unhealthy state. However, one can rightly hold the government accountable for failure to provide medical care for the person with lung cancer.
[30]Arif H Khan, 'Health and human rights' *Daily Star* (20 December 2007).
[31]See section 2 below for human rights instruments that establish health as a human right and not a human need.
[32](2003) AHRLR 96 (ACHPR 2003). This case is also cited by Kiromba Twinomugisha, 'Exploring Judicial Strategies to Protect the Right of Access' (2007) 7(2) African Human Rights Law Journal 283–306 at 288.

consequence of its omission? Accordingly to the International Covenant on Economic, Social, and Cultural Rights (ICESCR), there are ‘a number of steps’ that a State Party can take to achieve the full realization of the right to health. Such steps include:

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
(b) The improvement of all aspects of environmental and industrial hygiene;
(c) The prevention, treatment, and control of epidemic, endemic, occupational, and other diseases;
(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.[33]

A government is then said to have violated the right to health of its people if it fails to consider these steps to ensure that everyone can get medical assistance in time of need. In this context, the violation is a consequence of omission. However, a government can also violate the right to health through its actions. For instance, the ESCR Committee which oversees the implementation of the ICESCR has recommended that ‘the right of access to health facilities, goods and services on a non-discriminatory basis, especially for [the] vulnerable or marginalized groups is non-derogable.’[34] A state then violates the right to health especially of women, for instance, if it fails to provide rural women with access to emergency obstetric care (EmOC). According to Twinomugisha, ‘access to EmOC is a core component of the right to health, given that lack of it may result in the death or disability of large numbers of women.’[35] Paul Hunt has observed that:

> For every woman who dies from obstetric complications, about 30 more suffer from injuries, infection and disabilities. Over two million women living in developing countries remain untreated for obstetric fistula, a devastating injury of childbirth.[36]

The scarcity of resources normally limits the fulfilment of human rights. However, there is always a basic level of healthcare that everyone should be able to access. In its General Comment No 3, the ESCR Committee reiterates the States Parties’ core obligation to ensure the satisfaction of minimum essential levels of each of the right enunciated in the Covenant, although it leaves the minimum essential level of each right to the discretion of the incumbent States Party.[37] Moreover, the Alma-Ata Declaration provided that the provision of ‘primary healthcare’ is essential for the right to health.[38] Like all human rights, the ‘essence of the right to

[33]Art 12 (2) ESCR.
[34]ESCR Committee, ‘The Right to the Highest Attainable Standard of Health’, General Comment No 14 (2000) EC/12/2005/4 para 47.
[35]Twinomugisha (n 13) 291.
[36]Paul Hunt, ‘Statement to the United Nations General Assembly, Third Committee’ (2006).
[37]See General Comment No 3 para 10.
[38]See the 1978 Declaration of Alma-Ata. Although this declaration is not legally binding like human rights treaties, its message on the right to health is widely recognised in other international and regional human rights instruments as above.

health is in its aim of preserving human life and dignity.'[39] If this is true, then the key elements of a right to health include participation of all stakeholders, accountability, non-discrimination, equity and recognition of international legal, regional and national provisions of this.

2.3 The Ugandan national legal framework in support of the right to health

The supreme law of Uganda expressly provides for the protection and promotion of human rights of all peoples.[40] Accordingly, Uganda is required to take all practical measures to ensure the provision of basic medical services for the entire population, and also to promote access to the underlying determinants of health such as food, water, shelter and proper sanitation.[41] Precisely, the Constitution of Uganda upholds the human rights principle of non-discrimination and equality of all peoples. It states that 'all Ugandans enjoy rights and opportunities and access to education, health services, clean and safe water, work, decent shelter, adequate clothing, food security and pension and retirement benefits'.[42] However, as noted by the UHRC in its research on health rights, the provisions of this Constitution 'reflect a commitment but do not amount to an obligation since they fall outside the substantive sections of the Constitution.' Consequently, 'the right to health is neither appreciated nor understood within the medical and legal circles.'[43] It is not therefore surprising that there appear to be no court decisions existing in which judicial review has taken place on the basis of the right to health, and yet enormous incidences of violation of this right have occurred and continue to occur.

However, in an effort to actualise the constitutional provisions on the right to health, the Constitution of Uganda and the Local Government Act of 1997 downsized, restructured and decentralised the services of the Ministry of Health (MoH). Responsibility and authority for delivery of health services was brought down to the level of the district and other local authority entities such as municipalities. Since then, the MoH has introduced a sector-wide approach (SWAP) as the guiding principle in health planning and resource mobilisation.[44] The intention of the SWAP was to promote transparency, ease securing funds needed for capacity building, and procurement decision-making based on priorities.[45]

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[39]See Ginkgo, 'Leave the Lights On: Right to Health Care: One Working Definition' <http://www.leavethelightson.info/2008/06/right-to-health-care-one-working.html> accessed 20 August 2008.

[40]See Charter 4, Articles 21 (equality and non-discrimination), 22 (right to life), 33 (right to education), 34 (rights of children), 35 (rights of disabled people), 39 (right to clean and health environment) and 40 (economic rights) of the Constitution of the Federal Republic of Uganda, 1995.

[41]See Preamble paragraphs XX (on medical services), xxi (on clean and safe water), and xxii (on food security and nutrition) of the Constitution of the Federal Republic of Uganda, 1995.

[42]See Preamble paragraph XIV (ii).

[43]See The Executive Summary of 'The Voice of Patients: The State of the Rights of Patients and their attendants in Uganda' (Uganda Human Rights Commission, Kampala 2005) x, hereafter, UHR Research on Health Rights.

[44]See MoH, Report of Uganda Health Facilities Survey (UHFS) 2000, 1.

[45]Ibid.

While the Constitution of Uganda and the Local Government Act of 1997 are steps in the right direction to promote the right to health in Uganda, they are not enough to guarantee the same. The Uganda National Health Policy of 1999 has provisions on the legal aspects of health but it lacks enforcement mechanisms to make sure that those provisions are implemented. Its policy objective is to 'review and develop the relevant legal instruments that govern and regulate health and health-related activities in the country, in order to ensure that principles and objectives of this policy are attained'.[46] In this line, the policy commends the government to update, formulate, and disseminate laws, regulate and put in place enforcement mechanisms for a number of health-related issues.[47] However, more remains to be accomplished by the government in this regard.

The existing regulatory framework to monitor the health service delivery in Uganda is inevitably weak. The National Drug Authority which performs this function is inefficient due to the lack of a clear legal framework. While it is meant to control the procurement and distribution of drugs in Uganda, the National Drug Authority (NDA) is not effective in controlling the sale and purchase of medicines in the country. Many people, especially the poor, can buy any medicine from any drug shop without consulting a doctor. This has grave consequences, as people may buy expired drugs or overdose or underdose, as the case may be. This has led to increased antibiotic resistant bacteria in Uganda. In an article, 'Drug authority raids fake shops in Kayunga', in the *New Vision*, Kibuuka reported the confiscation of 500 containers of fake drugs by Phoebe Mukasa, the District Drug Inspector. He also reported the instant death of John Ssenfuka, 17, a resident of Magalagata village in Galiraaya sub-county, after taking the drugs he bought in a shop. A post-mortem carried out in Kayunga hospital indicated that Ssenfuka had taken expired drugs.[48] It is also not uncommon for people to buy strong drugs freely from the clinics.

There is, therefore, a need for some positive health laws in the country to regulate a number of health-related issues, including the provision and maintenance of the determinants of health. Uganda needs laws related to various aspects of health, such as epidemic diseases like Ebola, prevention of malaria ordinance, laws related to eye surgery, quality of food women and children's health and so

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[46]See 'Legal Aspects of Health', section 13 of the Ministry of Health National Health Policy 1999 <http://www.health.go.ug/docs/NationalHealthPolicy.pdf> accessed 28 December 2007.

[47]These include laws regarding: a) 'the development and control of the National Heath Service; b) Traditional Medicine, including Traditional Midwifery; c) the training in and conduct of medical and health research; d) The importation, Manufacture, use and disposal of hazardous materials; e) The protection of employees against health hazards related to their employment in liaison with relevant organisations; f) Food hygiene and safety; g) Government Notice No. 245 of 1961 that governs and regulates the Religious Medical Bureaux; h) Environment Health Control; i) Consumer protection, especially for the vulnerable groups including women, children and persons with disability; and j) Stigmatisation and denial due to ill health or incapacity.' Ibid.

[48]See Kibuuka Lumu, 'Drugs authority raids fake shops in Kayunga' *New Vision, Uganda's Leading Daily* (10 December 2005).

on, and crucially, laws that deal directly with the rights of patients/clients are urgently required.[49]

Recently, some people have argued that even in the absence of such direct positive health laws in the country, there are numerous windows of opportunity in Uganda to improve the human rights situation in general and the right to health in particular. Twinomugisha, for instance, has pointed out and elaborated the responsibility of the Ugandan Judiciary to help the government of Uganda to promote the full realisation of the socio-economic rights including the right to health.[50] He argues that while the Constitution may not be explicit on human rights, it recognizes that 'fundamental rights and freedoms of the individuals are inherent and not granted by the state'[51] and as such 'shall be respected, upheld and promoted by all organs and agencies of government and by all people.'[52] He cites article 50 which provides that 'Any person who claims that a fundamental right or freedom guaranteed under this Constitution has been infringed or threatened, is entitled to apply to a competent court for redress which may include compensation.'[53]

The same article also provides that 'any person or organisation may bring an action against the violation of another person's or group's human rights.'[54]Accordingly, individuals or non-governmental organizations can authentically represent others whose human rights have been violated before a competent court and the court has to interpret the constitutional provisions in defence of human rights.[55] Normally, it is the Court of Appeal (sitting as the Constitutional Court) which is competent to interpret the constitution in Uganda,[56] even in cases involving violation of human rights and freedoms, as in *Attorney-General v Tinyefunza*[57] and in *Sergo v Kampala City Council*.[58] However, according to Justice Kanyeihamba, in *Simon Kyamanywa v Uganda*,[59] 'any court and tribunal which is properly constituted has jurisdiction to hear and determine any dispute arising from the application and enforcement of any provision of the Constitution.'[60]

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[49]The Ugandan Human Resources for health Policy 2006 invites the government of Uganda to 'ensure that roles, mandates and responsibilities of various bodies dealing with regulation, standards and maintenance of ethical conduct are clearly defined, and regularly communicated; [and also to] ensure that effective legal and monitoring mechanisms for dealing with patient / client grievances are in place, while deploying appropriate advocacy to educate patients /clients on their patient rights.' See Uganda Ministry of Health, Human Resources for National Health Policy 2006 <http://www.health.go.ug/docs/HRH_Policy_Final.pdf> accessed 28 December 2007.

[50]Twinomugisha (n 13) 294.

[51]Art 20(1) Ugandan Constitution.

[52]Art 20(2) Ugandan Constitution.

[53]Art 50(1) Ugandan Constitution.

[54]Art 50(2) Ugandan Constitution.

[55]See GP Mukubwa, 'The Promotion and Protection of Human Rights in Africa, (2006) 6 East African Journal of peace and Human Rights 130.

[56]Art 137(1) Ugandan Constitution.

[57]Constitutional Appeal 1 of 1997, 11–13.

[58]Constitutional Appeal 2 of 1998.

[59]Criminal Appeal 1 of 2000 (unreported), see Twinomugisha (n 13) 296.

[60]Constitutional reference 10 of 2000. See 2000(2) EALR 434.

It has been established that the 1995 Ugandan Constitution directly provides for some rights such as the right to education,[61] the rights of family,[62] the rights of women,[63] children,[64] minorities,[65] cultural and economic rights,[66] and a right to a clean and healthy environment.[67] However, it mandates the National Objectives and Directive Principles of the State policy (NODPSP) to 'guide all organs and agencies of the state … in applying or interpreting the constitution or any other law'[68] and 'in implementing any policy decisions [of the government]'.[69] The NODPSP is very clear about the right to health. It provides that the State is to 'take all practical measures to ensure the provision of basic medical services to the population.'[70] It also directs the state 'to fulfil the fundamental rights of all Ugandans to social justice'.[71] Accordingly, the Ugandan government is to make sure that 'all Ugandans enjoy [their human] rights and opportunities, and access … health services'.[72] As Twinomugisha has argued, even where the courts doubt the enforceability of the NODPSP, and where there are no specific provisions on a particular matter in the Constitution, the courts can reckon on the jurisprudence from India, and from the 'treaty bodies and case law from other jurisdictions that have considered related provisions.'[73] This is a plausible argument since in so doing the Ugandan courts will be fulfilling 'their constitutional mandate to respect, protect and uphold human rights.'[74]

It is correct to argue that the Ugandan courts can viably assess 'the practicability of measures the state has instituted to address the question of access to health or medical services',[75] and, specifically, examine the extent to which the government policy translates into budgetary measures to respect, protect, and fulfil the rights of the people to access health services. However, how many such courts can practically do it? The experience in Uganda is that the courts are already overloaded with thousands of pending cases due to lack of manpower and financial resources, it is therefore very unlikely that the courts will be able to spare time to scrutinize government policies regarding the fulfilment of socio-economic rights, including the right to health. Moreover, there will be little motivation for some individuals, groups or non-government organisations to take a complaint before the court on behalf of others whose human rights have been violated, especially if the violation is on a massive scale, which makes such a situation appear acceptable. It is crucial to have in place, clear laws that condemn such massive violation of human rights especially the right to health of women and children. Critically, HIV/AIDS-related legislation needs to be enacted with immediate effect for the benefit of all.

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[61] Art 30.
[62] Art 31.
[63] Art 33.
[64] Art 34.
[65] Art 36.
[66] Art 37 and 40.
[67] Art 39.
[68] See National Objectives Directive Principles of State Policy (NODPSP) 1(i).
[69] Ibid.
[70] NODPSP XX.
[71] NODPSP XIV.
[72] NODPSP XIV (b).
[73] Twinomugisha (n 13) 297.
[74] Ibid 298.
[75] Ibid.

2.4 Jurisprudence on the right to health

Uganda needs to emulate the examples of other national constitutions that categorically defend and promote the right to health. For instance, article 27 of the Constitution of South Africa expressly recognises the right to health:

(1) Everyone has the right to have access to health care services, including reproductive health care; sufficient food and water; and social security, including, if they are unable to support themselves and their dependants, appropriate social assistance must be accessible.
(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.

Such clear provisions on the right to health in the national constitution make it easy for the victim whose right has been violated to be defended in courts of law. Already, at least two cases on the right to health have been recorded by the South African Constitutional Court.[76] In *Soobramoney v Minister of Health (Kwazulu)* the court had to decide whether a local hospital had violated the right to healthcare expressed in article 27 above by refusing to provide the plaintiff Mr Soobramoney with periodical renal dialysis treatment necessary to maintain his life. Although the court ruled in favour of the Minister of Health, stressing the need for non-interference of the court in rational decisions taken in good faith by the political organs and medical authorities at the political level, in fixing the health budget, and at the functional level, in deciding upon priorities to be met,[77] it raised the profile of the right to health in South Africa.

Article 196 of the 1988 Constitution of Brazil, details the right to health in the following words:

> Health is a right of everyone and a duty of the State, guaranteed by social and economic policies aimed at reducing the risk of illness and other hazards and at universal and equal access to the actions and services for its promotion, protection and recovery.

Due to this clear right to health provision in the national constitution of Brazil, the Brazilian courts have been able to defend the right to health. For instance, more often than not in cases involving the State's denial of access to HIV/AIDS treatment to patients, the courts have often generally interpreted the right to health and ruled against the State and ordered it to provide medical treatment to the public. In *Dina Rosa Vieira v Municipality of Porto Alegre*, the plaintiff claimed that she was entitled to receive free HIV treatment from the local government as a corollary of her right to healthcare according to article 196 cited above. Although the defendant gave lack of resources as the reason for this, the Supreme Federal Tribunal rejected the defendant's argument, and found it to have violated the rights to life and

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[76]Soobramoney v Minister of Health Kwazulu-Natal; and Minister of Health v Treatment Action Campaign <http://www.concourt.gov.za>.
[77]Constitutional Court of South Africa, Case CCT 32/97, 27 November 1997.

healthcare guaranteed in the Brazilian Constitution. The Tribunal ordered the State to provide all treatment needed by the plaintiff.[78]

In *Choose v Byrne*, the Supreme Court of New Jersey contested the legality of a statute which prohibited the medical funding of abortions except where it was medically proved to be necessary for preserving the woman's life. The plaintiffs claimed that the denial of medical funds violated the human rights assured by the due process and equal protection clauses of the New Jersey and US Constitutions. The Supreme Court concluded that this statute violated the 'fundamental right to health under both constitutions'.[79]

The European Court of Human Rights has given a ruling on non-interference with information related to family planning services and pre- and post-natal care. In *Open Door and Dublin Well Women v Ireland*, the European Court of Human Rights ruled that there had been an interference with the right of the applicant counsellors to impart information and the right of Mrs X and Ms Geraghy to receive information in the event of pregnancy. There was a violation of ECHR article 10.[80] It is therefore clear that a number of countries take the right to health seriously by putting in place a legal framework to protect and promote it.

2.5 The role of the UN Special Rapporteur on the right to health

The UN Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health (the right to health) plays an important role in explicating the legal basis of this right in many of his country mission reports to the UN General Assembly and to the Commission of Human Rights.[81] These reports offer a viable source of law and guidance on the practical implementation of the right to health.[82] For instance, in his report from the Ugandan mission, 17–25 March 2005, he identified key features on the right to health approach to neglected diseases. These included: the government's legal duty to provide access to health

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[78]*Dina Rosa Vieira v Municipality of Porto Alegre,* Decision No. RE-271286.

[79]See *Choose v Byrne,* Supreme Court of New Jersey, 91 NJ 287; 450 A 2d 925, 18 August 1982.

[80]See ECHR, judgment of 29 October 1992, A 246; Also S Coliver (ed.), '*The Right to Know, Human Rights and Access to Reproductive Health Information', Article* 19 (University of Pennsylvania Press, Philadelphia 1995) 329.

[81]On 22 April 2002, at the 49th meeting, the Commission on Human Rights in resolution 2002/31, appointed Paul Hunt, as Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health. He was mandated to: gather, request, receive and exchange right to health information from all relevant sources; dialogue and discuss possible areas of cooperation with relevant actors, including governments, relevant United Nations bodies, specialised agencies and programmes, in particular the WHO, and the Joint United Nations Programme on HIV/AIDS, as well as non-governmental organisations, and international financial institutions; Report on the Status, throughout the world, of the right to health, including laws, policies, and good practice and obstacles; and make recommendations on appropriate measures that promote and protect the right to health.

[82]The Missions he has undertaken include: Mission to Uganda, 17–25 March 2005, see E/CN 4/2006/48/Add 2; Mission to Mozambique, December 2003, see E/CN 4/2005/51/Add 2; Mission to Peru, June 2004, see E/CN 4/2005/51/Add 3; Mission to Romania, August 2004, see E/CN 4/2005/51/Add 4; Mission to the World Trade Organisation, 16 to 23 July 2003 and 27 to 28 August 2003, see E/CN.4/49/Add.1.

information and education for all people, on the prevention and health promoting behaviour, as well as on how to access health services;[83] the right of individuals and communities to informed and active participation in health decision-making which affect them[84] (which Uganda encourages in the Preamble of its Constitution [Article II (i)] and promotes in practice through involving CSOs in the preparation of Uganda's PRSP/PEAP,[85] and through its new policy on decentralization in the health sector);[86] Uganda's legal requirement to devise a coherent strategy and a cost plan of action to train and maintain health professionals in the health sector, to alleviate the deprivation of the most disadvantaged communities in remote areas of their right to healthcare services.

The Special Rapporteur also reiterates that the principle of non-discrimination and equal treatment in relation to the right to health has a legal foundation in international law and is an obligation which should be given immediate effect. He encourages Uganda to take measures to ensure that health policies and practices promote equal access to health services, and to integrate a gender perspective throughout its policies and programmes.[87]

3. Uganda's legal obligations concerning the right to health

Like any other state that has ratified the binding international human rights instruments, Uganda has an obligation to ensure the right of everyone to the enjoyment of the highest attainable standard of health.[88] There are mainly three types of obligations for Uganda under the right to health, namely: respect, whereby it must refrain from directly or indirectly interfering with people's right to the enjoyment of the highest standard of physical and mental health;[89] protection, whereby through legislation it provides laws that prevent third parties such as corporations or investors from interfering with people's enjoyment of the right to health;[90] and the obligation, for instance, by taking positive and effective measures, to facilitate the progressive realisation of all human rights in general, and the right to health in particular.

The obligation to 'respect' requires a state to refrain from actions that endanger the health of an individual, as explained by Bothe.[91] In a way, and according to

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[83]See E/CN.4/2006/48 Add 2, paras 33 and 34.
[84]See E/CN.4/2006/48 Add 2, para 36.
[85]See PEAP 2000, Summary and Objectives, 12; PERSP, 'Resource Allocation to the Health Sector in Uganda', Paper no 7 (2004) 16.
[86]See Village Health Committees (Health Centre I to IV), in the HSSP of Uganda's PRSP.
[87]See the report of the Special Rapporteur on the Right to Health Mission to Uganda, 17–25 March 2005 (E/CN 4/2006/48/Add 2) para 54.
[88]UN Doc A/60/348, 7.
[89]The right to health is violated when government agents torture people physically or mentally, as it has been reported in many instances by the Uganda National Human Rights Commission Reports.
[90]For instance, a number of investors (international or national) may dispose of industrial wastage that unless caution is taken, can be hazardous to people's health.
[91]M. Bothe, 1979, p.14 (L'aspect négatif du droit à la santé signifié: l'individu a droit à ce que l'État s'abstienne de tout acte qui pourrait mettre en danger la santé de cet individu). 'Les Concepts Fondamentaux du Droit à la Santé: Le Point de Vue Juridique' in J. Dupuy, Le Droit à la Santé en tant que Droit de l' Homme. Colloque La Haye, 27–29 July 1978 (The Right to Health as a Human Right: Workshop, The Hague), pp 14–18.

Toebes, the obligation to respect is a 'negative obligation' for the State.[92] On the same point, Eide also had the following to say:

> The obligation to respect requires the State, and thereby all its organs and agents, to abstain from doing anything that violates the integrity of the individual or infringes on his or her freedom, including the freedom to use the material resources available to that individual in the way she or he finds best to satisfy the basic needs.[93]

It is incumbent on the Uganda government to provide access to healthcare facilities and to health-related information for the individual. At the same time, it is Uganda's obligation not to infringe on an individual's health, in the 'field of environmental health and physical integrity.'[94]

In short, Uganda's obligation to respect the right to health and the underlying determinants of health involves: respect for equal access to healthcare facilities by all people, especially in remote and underprivileged areas;[95] respect for equal access to family planning services and pre- and post-natal care; respect for equal access to water and sanitation; abstention from environmental and industrial policies detrimental to health; no interference with the provision of healthcare, healthcare related services, such as water and sanitation, and no interference with environmental and industrial health-related information.

Uganda's legal obligation not to discriminate in the provision of access to healthcare and underlying determinants of health also includes actions that have the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health. Discrimination can occur mainly if all people do not have equal access to safe and portable water, adequate sanitation, a healthy environment, health education, an adequate supply of food, nutrition, and adequate housing.

3.1 The nature of the obligations

The obligations to protect and to fulfil are of a positive nature. Both require the Ugandan government to take certain measures to protect and assist the rights of people. According to Eide, the obligation to protect requires the state and its agents to take 'measures necessary to prevent other individuals or groups from violating the integrity, freedom of action, or other human rights of the individual – including the prevention of infringement of the enjoyment of his material resources.'[96] Van Hoof is more specific when he argues that the obligation to protect means 'to take steps – through legislation or otherwise – which prevent others or prohibit others

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[92]See Brigit CA Toebes, The *Right to Health as a Human Right in International law* (Intersentia-Hart, Oxford 1999) 312.

[93]See A Eide, 'The New International Economic Order and the Promotion of Human Rights', UN Doc E/CN 4/Sub 2/1987/23, July 1987, s 67.

[94]Toebes (n 92) 313.

[95]The Reporting Practice of ICESCR mentions people living in remote rural areas (the minorities and indigenous populations, women, children, the elderly, the mentally ill, disabled persons, persons with HIV/AIDS, and drug and alcohol addicts) as those usually denied access to healthcare facilities. See Toebes (n 92) 116.

[96]See Eide (n 93).

(third persons) from violating recognized rights or freedoms'.[97] Accordingly, Uganda is challenged to demonstrate the steps it has taken to protect HIV/AIDS victims from exploitation by non-government organisations that solicit funds to support them. In a similar vein, Uganda needs positive laws to apprehend those who deliberately and maliciously infect others with HIV/AIDS. Uganda is under a legal obligation to protect citizens against certain practices imposed by private healthcare providers, traditional healers, in order to safeguard the quality and the accessibility of the healthcare services provided.[98]

However, most important of all, Uganda has a core legal obligation to ensure the satisfaction of, at the very least, the minimum essential levels of each right enunciated in the Covenant, including essential primary healthcare.[99] The following sum up the core, legal obligations of Uganda's right to health, according to General Comment No 14:

(a) An obligation to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;
(b) An obligation to ensure access to the minimum essential food which is nutritiously adequate and safe, to ensure freedom from hunger to everyone;
(c) An obligation to censure access to basic shelter, housing and sanitation, and an adequate supply of safe and clean water;
(d) An obligation to provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
(e) An obligation to ensure equitable distribution of all health facilities, goods and services;
(f) An obligation to adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as rights health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.[100]

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[97]GJH van Hoof and K de vey Mestdagh, 'Mechanisms of International Supervision' in P van Dijk (ed.) *Supervisory Mechanisms in International Economic Organisations* (Kluwer/TMC Asser Institute 1984) 106. Also see Article 12(of the ICESCR; General Comment No 3, 1990, paras 3, 4,and 7; and the Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, UN Doc E/CN.4/1987/17, paras 17 and 18; (1987) 9 Human Rights Quarterly 122–135.
[98]Toebes (n 92) 328.
[99]See AR Chapman and S Russell (eds.), *Core Obligations: Building a Framework for Economic, Social and Cultural Rights* (Intersentia, Oxford 2002), especially the different articles on the minimum core obligations under each of the rights recognized in the Covenant; and David Bilchiz, 'Giving Social-Economic Rights Teeth: The Minimum Core and its Importance' (2002) 118 The South African Law Journal, 484. He defends the principle of minimum core obligation based on the moral principles of priority and basic needs.
[100]See General Comment No 14 para 43.

It is Uganda's legal obligation to establish an integrated health system responsive to its local priorities, according to the report on the Uganda Mission by the UN Special Rapporteur on the right to health.[101] Such a system should be flexible enough to cater for neglected diseases, outbreaks of communicable diseases (e.g. HIV/AIDS, tuberculosis, and malaria).

3.2 Progressive realisation of the right to health

It is a truism that the right to health cannot be realised immediately and overnight because of resource constraints and time needed to put the infrastructure in place. But the progressive realisation recognizes the limits of availability of resources. The ICESCR can not absolve Uganda for not advancing the right to health on grounds of limited resources. It imposes an immediate obligation on Uganda to ensure that it constantly moves towards improving the health and wellbeing of its people. Uganda must take deliberate, concrete and targeted steps towards the full realization of the right to health of the people under its jurisdiction.

Many advocates of the right to health place great emphasis on developing indicators and benchmarks as tools to monitor and account for the progressive realization of the right to health. The same is stressed by General Comment No 14.[102]

The UN Special Rapporteur on the Right to Health is very explicit about the use of indicators in his 2003 and 2004 reports to the Committee on Human Rights and the General Assembly. His 2006 report to the Commission on Human Rights is particularly important for it sets out a framework for considering health indicators from a rights-based approach. He lays emphasis on the importance of health indicators, but warns that they should be disaggregated on grounds such as sex, race and ethnicity. He specifies three types of indicators: structural; process and outcome.[103]

3.3 Obligation to seek international assistance

It is Uganda's obligation to seek international assistance and cooperation in order to access more resources needed to achieve the progressive realization of the right to health.[104] But other States have an international obligation under articles 55 and

[101] See the Report of the Special Rapporteur (n 87) para 55, 59.
[102] See General Comment No 14 paras 57–58.
[103] See the Reports of the Special Rapporteur on the Right to Health to the General Assembly in 2003 (A/58/427); 2004 (A/59/422); and to the Commission on Human Rights in 2006 (E/CN 4/2006/48).
[104] See Paul Hunt, 'Using Rights as a Shield' (2002) 6(2) *Human Rights Law and Practice,* where he encourages developing countries to use the Covenant to demand international assistance from the developed States. See also Dr Octavio Ferraz and Judith Mesquita, 'The Right to health and the Millennium Development Goals in Developing Countries: A Right to International Assistance and Cooperation' (University of Essex 2006; a copy with the author). He maintains that there is a right to international assistance and cooperation (p 12 footnote 22); see also Sigrun Skogly, Beyond National Borders: States' Human Rights Obligations in International Cooperation (Intersentis, Oxford 2006) 17 and 18 where the author observes that, although the debate on whether there is a right to international assistance and cooperation is not yet concluded, all countries, rich and poor have obligations in their foreign relations to the extent that they influence the enjoyment of human rights for individuals in other countries.

56 of the UN Charter, to cooperate in the development and realization of all human rights.[105] In particular, in order to abide by the international obligation in relation to article 2(1) of the ICESCR, States Parties have to aid Uganda in promoting the right to health whenever Uganda makes a request for assistance. They are under an obligation at all times not to impose embargoes or similar measures that may restrict Uganda's supply of adequate medicines and medical equipment, (in line with General Comment No 14).[106]

What if those other countries also have resource constraints and hence may not be in a position to help Uganda? To such a question, one could argue, like UN Special Rapporteur Passim, that these countries should endeavour to help Uganda realize at least the minimum core obligation relating to the right to health as a matter of duty of international assistance and cooperation.[107]

The donor community deserves credit for supporting Uganda's health sector. The Health Policy Statement 2003/04 acknowledged that donors contributed 81% of the 2003/04 development health budget that is managed through a sector-wide approach. However, as noted by the UN Special Rapporteur on the right to health, there is still a 'wide gap between the cost of a national minimum health care package in Uganda and the funds that are presently made available for this purpose.'[108] According to the Health Sector Strategic Plan (HSSP), US$28 per person per year is needed to finance Uganda's national minimum health care package. This is too

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[105]For more detailed information on extra-territorial, trans-boarder or trans-national obligations see Sigrun Skogly, 'The Obligation of International Assistance and Cooperation in the International Covenant on Economic, Social and Cultural Rights', in Morten Bergsmo (ed.) *Human Rights and Criminal Justice for the Downtrodden. Essays in Honour of A Eide* (Martinus Nijhoff, Leiden 2003) 403–420; Rolf Künnemann, 'Extraterritorial Application of the International Covenant On Economic, Social and Cultural Rights' in Fons Coomans and Menno T. Kamminga (eds) *Extraterritorial Application of Human Rights Treaties* (Intersentia, Antwerp 2004); International Council on Human Rights Policy (2002) <http://www.ichrp.org/paper files/108 w 02.doc>; Magdalena Sepulveda, *The Nature of the Obligations under International Covenant on Economic, Social and Cultural Rights* (Intersentia, Oxford 2003); Koen De Feyter, *World Development Law* (Intersentia, Oxford 2001). See also ICESCR articles 2.1 and 12; CRC article 4; UN Charter articles 55 and 56; UD on Human Rights, articles 22 and 28.

[106]General Comment No 14, para 39 concludes that: 'States parties have to respect the enjoyment of the right to health in other countries and to prevent third parties from violating the right in other countries … States should facilitate access to essential health facilities, goods and services in other countries, whenever possible, and provide the necessary aid when required … to ensure that the right to health is given due attention in international agreements … that their actions as members of international organizations take due account of the right to health. Accordingly, States parties which are members of international financial institutions pay greater attention to the protection of the right to health in influencing the lending policies, credit agreements and international measures of these institutions.' See also the concluding observations of CESCR on International Assistance and Cooperation (IAC) on UK, 2002, UN Doc EC 12/1/Add 79, para 26 and on Italy, 2004, UN Doc E/C.12/1/Ass 103, para 34, where the committee recommended each States Party to increase its ODA to 0.7% of its GDP for IAC; on Egypt, 2000, UN doc. E/C.12/1/Add 44, para 28; and on Ecuador, 2004, UN doc E/C.12/1/Add 100, para 56, also quoted by Ferraz and Mesquita (n 104).

[107]See David Lyons, 'The Correlativity of Rights and Duties' (1970) 4(1) Nôus 44–55. If the recipient countries have a right to international assistance and cooperation, then the more developed nations have a corresponding duty.

[108]See UN Special Rapporteur (n 87) para 74.

little according to the WHO's Report of the Commission on Macroeconomics and Health which puts US$30 to $40 per person per year as minimum financing to cover essential health interventions for a low-income country like Uganda.[109] Uganda's public expenditure from both the government and donors is only US$9 per person per year, in addition to US$7 per person per year from households and employers.[110] No wonder a UN report described Uganda as 'a basket case in chronic under-financing of the health sector.'[111] This under-funding to the health sector stifles the HSSP priorities, including reproductive services, human resources and health infrastructure.

4. How to apply a human rights approach to health in Uganda

A human rights approach to health can be considered at both the macro and micro levels. First of all it is important to realize that health is a human right with its foundation in international human rights law which regulates States' obligations and people's entitlements. Thus, all States are obliged to promote health as a human right under international human rights law, which bases itself on international treaties that States sign and ratify, and on international conventions and various mechanisms that operate in the UN and at the national level.[112]

At the macro-level, a human rights approach to health prescribes that Uganda provides adequate funding for health; promotes non-discrimination and equity in accessing health facilities; provides communication, transport, roads and ambulances; controls communicable diseases such as tuberculosis, Malaria, and HIV/AIDS; tackles environmental issues such as air pollution (due to dust, noise, industrial toxic gas); takes seriously the issue of neglected diseases; fights maternal and infant mortality; enacts a health law; creates laws regulating the procurement and distribution of drugs and other medical equipment; cares for the elderly; trains, recruits and retains health professionals in the country; and promotes all other determinants of health.

The micro-level is when human rights are considered as a conceptual system that analyses and guides the process of realizing the right to health, other than naming and shaming States that violate human rights. At the micro-level, a human rights approach to health adopts a critical evaluation of the relationship between the healthcare providers and the patients. It requires Uganda to examine the efficacy of the health laws in addressing such matters as: discriminatory practices in the provision of healthcare services; the approach requires Uganda to provide accurate healthcare information to the people, about when and where to turn for appropriate and timely healthcare; and delays in receiving care at the healthcare facility. It

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[109] See WHO, 2001, para 16. See J. D. Sachs, Report of the Commission on Macroeconomics and Health: Investing in Health for Economic Development (WHO, 2001), p. 16 <http://www.whqlibdoc.who.int/publications/2001/924154550x.pdf> accessed 15 July 2009.

[110] Ibid.

[111] Office of the UN Resident Coordinator, 'Uganda: Promise, Performance and Challenges: Attaining the PEAP and MDGs' (2003) 50.

[112] See LP Freedman, 'Using Human Rights in Maternal Mortality Programs: From Analysis to Strategy' (2001) 75 International Journal of Gynaecology and Obstetrics 51–60 at 53 <http://www.elsevier.com/locate/ijgo> accessed 12 May 2006.

tackles rights-based problems, including the dismissive attitude of healthcare providers towards patients; high market prices for hospital equipment; healthcare insurance that is sometimes unaffordable to the majority of the poor; and traditional health care providers.

The human rights-based approach calls for all stakeholders in the promotion of the right to health to hold in the highest esteem both the process and human interactions that are so crucial to the full realization of this right. Thus, dignity in health concerns both being free from avoidable diseases and the way individuals, communities and societies engage in the process of obtaining and maintaining the highest attainable standard of health.[113]

At both the macro- and micro-levels, human rights principles guide the analysis, design, implementation, monitoring and evaluation of health-related programmes. Such human rights principles include active and informed participation of all stakeholders in the process of delivering health-related programmes, accountability, non-discrimination, empowerment and linkages to human rights standards.[114] The government ought to create channels for the active, free and meaningful participation of all people, especially the poor and disadvantaged, in the design and implementation of health-related programmes. The channel of participation will enhance the possibility of targeting the most vulnerable as the priority beneficiaries of the health project. In accountability, the government's aim should be to put in place health-promotion infrastructure and to create fully responsible communities capable of managing their health facilities. Thus, the government is accountable to the people while the people are also accountable to the government on the extent to which they maintain and utilize the health facilities.

The principle of non-discrimination in health entails developing disaggregated data concerning the most vulnerable and disadvantaged members of the society to specifically focus on them. Interestingly, the Ugandan Constitution condones positive discrimination especially on policies and programmes 'aimed at redressing social, economic, educational or other imbalances in society.'[115] While the principle of empowerment involves building peoples' capacities to claim their rights especially their right to health and to seek remedy when this right is violated, in linking health related programmes to the relevant human rights standards, the government recognizes its legal obligation to promote the full realization of the right to health of its people.

5. The right to health in Uganda

The right to health in Uganda is not fully realised. However, it must be underlined that Uganda has registered tremendous progress in the design and implementation of programmes that contribute to the full realization of the right to health. For example, there was a reduction in the HIV prevalence rate from 6.8% in 1999 to 6.2% in 2000. The abolition of user fees in 2001 also led to an increase in health

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[113]See ibid 55.
[114]Sometimes these human rights principles are represented in an abrivieted form as 'PANEL' (Participation, Accountability, non-discrimination, Empowerment, and Linkage to human rights standards).
[115]Art 21 (4)(a).

service utilisation, especially Out Patient Department (OPD) attendance, from 41% in 1999 to 84% in 2002. The Ugandan government has also made remarkable progress in its campaigns to control malaria, TB, and measles. The number of health facilities is increasing throughout the country. Of late, the Ugandan government has signed contracts for the expansion of 39 health centres in the south-western part of the country and six regional referral hospitals. The World Bank is to fund the expansion of these health facilities with a soft loan of $18m under the Health Sector Support Programme II.[116]

5.1 The Uganda Ministry of Health and the right to health

The Mission of the Ugandan Ministry of Health is 'to provide a network of functional, efficient and sustainable health infrastructure for effective healthcare service delivery to all the people' in Uganda, thus bringing about the full realisation of the right to health. However, there are serious concerns as to whether this mission is being realized. The standard of the healthcare system is not yet up to people's expectations. There are internal and external factors that seem to prevent the Ministry of Health from achieving its objectives in the country.

a) Internal factors facing the Ministry of Health

These include the fact that the Ministry of Health is not following a fully human rights approach to health. This accounts for the continued existence of stigma among the poor members of society, most especially those suffering from neglected diseases. The poor and the most vulnerable are far from realising their right to health since not many are yet able to access adequate medical care. Sometimes there are no essential drugs and equipment in the health facilities. Corruption is still a common problem coupled with poor management of the available resources. Due to corruption, some Antiretroviral (ARVs) end up on the black market or in private clinics. Procurement of drugs at the district level is cumbersome and sometimes the drugs do not reach the poorer people. Asaph Byamukama agrees with this position when he argues that the Government tries

> hard to deliver ARVs to people throughout the country, and undoubtedly much has been achieved. Nevertheless, poverty, travel difficulties, maladministration and a host of other barriers show how hard it is to ensure that patients access the drugs that will extend their lives.[117]

Moreover, while there are institutional and legislative frameworks to address corruption in Uganda, the 'anti-corruption agencies remain weak, under resourced and poorly co-ordinated.'[118] For instance, the three former Health Ministers found

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[116]See *The New Vision, Uganda Leading Daily* (2 August 2008) <http://www.newvision.co.ug>.

[117]See Sserwanga Moses, 'Widening Access to HIV/AIDS Drugs in Uganda' <http://www.dfid.gov.uk/news/files/meta-uganda.asp> accessed 6 August 2008.

[118]See DFID Uganda Performance Framework and Development Plan 2006/07–2008/09 <http://www.dfid.gov.uk/pubs/files/uganda-performance-framework.pdf> accessed 6 August 2008.

guilty of mismanagement and misappropriation of Global Fund resources meant for fighting malaria, tuberculosis and HIV/AIDS, have not yet been prosecuted. This shows a weaker stance on corruption by the government.[119]

The Ministry of Health lacks sufficient personnel to cover the whole country. Thus, the health services are limited, especially in remote areas due to understaffing, and poor terms and conditions of work. The trained staffs are mostly in urban centres and normally refuse to relocate to up-country areas. The construction of new health centres in remote areas, and the rehabilitation and upgrading of existing health facilities has not yet been accomplished throughout the country in order to satisfy the demand.

b) External factors facing the Ministry of Health

The very poor state of the roads up-country worsens accessibility to health units, especially when it rains heavily. Moreover, there are very limited ambulance services, if any at all, to transport seriously ill patients to higher levels of care. Among the various reasons for this continued occurrence is the lack of sufficient funds available to the Ministry of Health to execute its obligations. There is, however, a serious reason accounting for the lack of sufficient funds to the Ministry of Health. The Ministry of Finance, Planning and Economic Development (MFPED), supported by IMF and the WB, controls the aid that goes to the health sector. It urges that, since Uganda depends on donor aid, further increases in aid will lead to an overvaluation of the Uganda currency and hence the 'Dutch disease' effect of aid, which will result in inflation, lower growth, and inhibit development of the tradable goods sector.[120] In order to prevent this situation, the MFPED places a ceiling on budget expenditures to any ministry and to donor aid to Uganda in general. However this is an unfounded fear in respect of the Ministry of Health expenditure. In fact 'growth in budget expenditures are necessary to achieve the country's commitments under the PEAP', and, moreover, the Ministry of Health can properly absorb more aid without causing inflation in Uganda, since it uses the funds overseas to import drugs and medical equipment which are not manufactured in Uganda. It needs more funds to set up more health facilities in order to combat crises such as HIV/AIDS and other infectious diseases. I agree with Sachs' argument that:

> Artificial ceilings on health expenditure, in the name of macroeconomic stability, are a false economy. There is no true stability without health, and the Ugandan economy

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[119] Ibid.

[120] For a detailed explanation of the 'Dutch Disease' see, CS Adam and DL Bevan, 'Aid, Public Expenditure and the Dutch Disease' (7 February 2003) <http://econwpa.wustl.edu/eps/dev/papers/0409/040927.pdf> accessed 18 December 2005.

> can fully absorb [any] massive increases in foreign grants for health than [what the] donors are likely to make available.[121]

One might conclude that 'the IMF, World Bank and Ugandan Finance Ministry have decided that protecting against inflation is more important than protecting people's lives.'[122] The Uganda Debt Network once reported that there were instances where the donors' funds were rejected by the MFPED, citing macroeconomic concerns.[123] However, it is imperative to assert that the link between health status and economic growth is very strong. As Bloom says, 'a healthy population leads to a productive labour. When people are healthy, they increase their life cycle savings for further investments.'[124] The Ugandan government should address the shortage of funds to the health sector by increasing domestic resource mobilisation and by appealing to bilateral donors to increase their support to the Ministry of Health. The World Bank cancelled Uganda's debt worth US$3.764B (about Ugandan shillings 7 trillion). This is good practice, which should be emulated by other donors. It is assumed that a portion of that money will go a long way to raise the standard of health care in Uganda.

5.2 The right to health in the Uganda Poverty Reduction Strategy Plan

The PRSP was first designed in 1999, as directed by the World Bank and IMF. A desk review of Health Sectors I and II in the Uganda PRSP reveals a considerable amount of information about the measures taken to implement the right to health in Uganda. It is established that the Uganda Poverty Eradication Action Plan (PEAP) is widely praised as a comprehensive and realistic poverty-reduction strategy, grounded in the Medium-term Expenditure Framework (MTEF). However, it is arguable that the strategy does not qualify to be pro-poor.

The PEAP does not consider health as a fundamental human right. This probably explains its lack of measurable indicators to monitor short-term progress in the implementation of the right to health. Crucially, the HSSP has 'a limited discussion of financial barriers to [healthcare] … the impoverishing impact of

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[121]Sachs (2000); See also Gustav Ranis, who argues that 'it is sometimes claimed that foreign capital, … can have a negative influence on developing country performance via the so-called "Dutch Disease" which, in its narrow definition, focuses on the exchange rate, rendering it unduly strong and thus discouraging possible labour intensive exports. However, given the diminishing role of the World Bank in lending to most countries, this relatively narrow interpretation of the 'Dutch Disease' probably does not carry a lot of weight', see G Runis, *Ownership, Dutch Disease, and the World Bank* (Yale University, New Haven, CT April 2003); quoted in R Hammonds and Gorik Ooms, 'World Bank Policies and the Obligations of its Members to Respect, Protect and Fulfill the Right to Health' (2004) 8(1) Health and Human Rights 27–60 at 59, fn 91. See J. D. Sachs, 'Letter to the Members of the Government of Uganda, Honorable Ladies and Gentlemen', 17 May 2001, p. 1 <http://www.wemos.nl/Documents/letter-Sachs-on-uganda.pdf> accessed 15 July 2009.

[122]See Professor Omaswa, as quoted in W Nyamugasira and R Rowden, 'New Strategies, Old Loan Conditions' (April 2002) <http://www.brettonwoodsproject.org/topic/adjustment/Ugandaanalaysis.pdf> accessed 18 December 2005.

[123]Uganda Debt Network (n 3).

[124]DE Bloom, D Canning and J Sevilla, 'The Effect of Health on Economic Growth: Theory and Evidence' Working Paper #8587 (National Bureau of Economic Research, Cambridge, MA 2001).

catastrophic' illnesses like HIV/AIDS, 'or accidents; lack of focus on people with disabilities (often the poorest of the poor); no discussion on non-communicable diseases such as those caused by smoking',[125] together with a failure to address the problem of neglected diseases.

While 'Uganda's approach to HIV/AIDS is widely regarded as a model on how other African States can fight the epidemic',[126] the HIV/AIDS greatly affect the country's healthcare system. There are about 2 million Ugandan orphans due to AIDS.[127] On 15 May 2008, Moses Sserwanga reported that only between 80,000 and 100,000 people access ARV drugs (the main treatment, which can stop people from becoming ill for many years) free of charge, while at least another 100,000 HIV-positive Ugandans do not have 'access to these life-saving medicines.'[128] There is therefore a need to retool Uganda's approach to HIV/AIDS through the prism of human rights to make it more transparent and efficient to benefit all the HIV/AIDS victims in the country.

In Uganda the idea of health insurance is still new. Health insurance companies are just coming onto the market. This calls for a need to control those who might be inclined to exclude persons such as the elderly, the disabled, or others with certain diseases, or those who cannot afford to pay, since these companies are after maximising profits. Charles Bwogi reported that many insurance companies had been excluding the coverage for people living with HIV/AIDS despite the fact that 'insurance policies are meant to offer social-health protection to all groups of people'.[129] A number of healthcare insurances have appeared in Uganda, including Microcare; OracleMed, a South African-based company; and Health Maintenance Organisations (HMOs) like International Air Ambulance (IAA) and AAR who offer health insurance products.[130] The current Insurance Act (2005) which created the Uganda Insurance Commission that regulates health insurances does not have provisions for regulation of the HMOs. Unlike proper insurance companies, the HMOs do not have to deposit one billion Uganda shillings with the Uganda Insurance Commission before registration. The implication of this is that in the case of a big claim or an act of insolvency on part of the HMOs, the client loses out completely.[131] Uganda should revise its insurance regulations to include provisions that govern the operation of HMOs, or otherwise they should operate as proper insurance companies.

The *New Vision* of 7 June 2006 reported that the long-awaited social health insurance scheme (SHI) would start operating in July 2007. However, as it was first to target employees of the formal and informal sector, the poor and most vulnerable

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[125]Uganda Debt Network (n 3).
[126]See Management Sciences for Health: Uganda <http://www.msh.org/global-presence/sub-saharan-africa/uganda.cfm> accessed 6 August 2008.
[127]Ibid.
[128]See Moses (n 117).
[129]Charles Bwogi quoting Dipankar Mahaalanobis, the Managing Director of Microcare in Charles Bwogi, 'HealthCare Insurance schemes taking shape' *New Vision, Uganda's Leading Daily* (28 September 2005).
[130]The HMOs have been operating as risk-bearing entities, insurers and healthcare providers whereby they take fees from the clients which they use to pay medical expenses, while retaining what is left at the end of the year as profit to clinics that agree to provide unlimited services for an annual fee to community-based financing schemes.
[131]Bwogi (n 129).

would be left out. According to Dr Francis Runumi, Commissioner for Health Planning, the social health insurance cover was 'to start with those who earn salaries from either the formal or informal sector'.[132] It is clear that this health insurance scheme is discriminative against the majority of the poor who have no substantial employment. What provision is there to cater for such people?

Despite the potential environment for the protection and promotion of the right to health in Uganda, the truth of the matter is that a great deal needs to be done before it can be claimed that a right to Health exists. The HSSP needs redesigning according the human rights principles of participation, accountability, non-discrimination, empowerment and focus on human rights standards as explained in the following paragraphs.

a) Participation

All the stakeholders must take an active part in both the design and implementation of a healthy strategy that affects their lives. It is imperative that any effort to bring about the progressive realisation of the right to health considers the importance of achieving health-related objectives and the process by which such objectives are achieved.[133] The Uganda HSSP has no evidence to prove that the poor actively participate in the design, implementation, or in monitoring the process, aimed at bringing about the realisation of their right to health, 'even though UPPAP reports suggest that Health Unit Management Committees (HUMCs) can be used to ensure accountability and monitoring by the community'.[134] In this regard, the health component of the Uganda PRSP does not reflect the views of the poor regarding their right to health. Thus, there exists a serious violation of the right health of the poor.

b) Accountability mechanism

In a human rights-based approach to development, rights imply duties, and duties demand accountability. This approach identifies duty bearers (the State) who are responsible for ensuring that human rights in general are fulfilled, and the right to health in particular is realised. It also identifies the poor and most vulnerable as the rights claimants who hold the States accountable for any failure in their duties. Unfortunately, the HSSP does not seem to provide for the accountability mechanisms through which the poor could demand their rights from the government.

An accountability mechanism is not for blame and punishment only. On the contrary, it can lead to the discovery of what does and does not work and why, thereby identifying where improvement is needed. Uganda needs to set up a right to health accountability mechanism that will establish which health policies and institutions promote the right to health of the poor and which do not.

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[132] Dr Francis Runumi, the Commissioner for Health Planning at the Ministry of Health, announced that the new scheme would begin on 1 July 2007. He made this announcement on Monday, 5 June 2006, while presenting a paper on the principles of social health insurance to a stakeholders' meeting in Mbale, Uganda.

[133] See the Report of the UN Special Rapporteur on the Right to Health UN Doc A/60/348, submitted in accordance with Commission Resolution 2005/24, 12.

[134] Uganda Debt Network (n 3).

There are a number of proper and effective mechanisms to hold the duty bearers accountable for failure to secure programmes that contribute to the progressive realisation of the right to health. In Uganda, there are both judicial and quasi-judicial means that the poor could use to pressurise the duty bearers to bring about progressive realisation of the right to health. The judicial means include the national courts of law,[135] while the quasi-judicial include the Uganda Human Rights Commission, human rights organisations (like the HRINET, the Uganda women lawyers) and political devices like Parliament. However, there is not much evidence in Uganda to show that the poor are using these mechanisms to hold the state and other duty bearers to account for the slow pace of progress made over the years in bringing about the full realisation of the right to health. Documented court cases are not available as yet. There are very few cases, if any, reported by the Uganda Human Rights Commission regarding the compensation of victims whose right to health is violated, giving the wrong impression that there are no such incidences.

Accountability procedures extend to the recipient governments as well as to the donor community, intergovernmental organisations, international NGOs and to trans-national corporations whose actions can violate or promote the right to health of the poor.[136] The Paris Declaration on Aid Effectiveness provides a good example of how to establish accountability mechanisms at different levels. At the international level, it established mechanisms whereby donors and recipient governments are held mutually accountable to each other.[137] At the national level, the Paris Declaration encourages partners and donors to make a joint mutual assessment of progress made in the implementation of the agreed commitments on aid effectiveness through the use of local mechanisms such as consultative groups.[138]

c) Non-discrimination

Despite its recognition of improved health as the key to poverty reduction, ‘the basic health services as presented in the primary health care package and disease control programmes are not poverty focused and do not focus on the poor and most vulnerable members of society.’[139]

The HSSP ought to have disaggregated data and a detailed discussion on the causes of health inequality and the financial barriers that hinder the poor from

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[135]The Constitution of the Republic of Uganda provides for the enforcement of Rights and Freedoms by Courts. Article 50(1) says that ‘Any person who claims that a fundamental or freedom guaranteed under this Constitution has been infringed or threatened, is entitled to apply to a rights and competent court for redress which may include compensation; (2) Any person or organisation may bring an action against the violation of another person’s or group’s human rights; (3) Any person aggrieved by any decision of the court may appeal to the appropriate court; and (4) Parliament shall make laws for the enforcement of the rights and freedoms under this Chapter’ (see Chapter 4).

[136]See the Paris Declaration on Aid Effectiveness: Ownership, Harmonisation, Alignment, Results and Mutual Accountability (Paris, 28 February–2 March 2005). This Declaration created strong mechanisms for mutual accountability.

[137]Ibid at para 9.

[138]Ibid at para 50.

[139]Uganda Debt Network (n 3).

accessing healthcare services. It must also articulate the issues of non-communal diseases and the concerns of disabled peoples among the poor communities.

A human rights-based approach obliges the primary healthcare policy-maker to provide for a clear outreach framework for reaching all the communities, especially those lacking adequate health facilities. It must provide for the training of healthcare workers, the construction of health units in underserved areas, the development of health services at the community level and the facilitation of effective outreach. This would create an effective platform for launching prevention and control messages and approaches.

However, there seems to be little evidence of pro-poor targeting or attempts to adopt a national strategy to meet the needs of the poorest in the health component of the Uganda PRSP. The strategy to improve health services in rural areas in Uganda is not yet viable. Although the HSSP has registered some progress in the provision of health services and the improvement in health infrastructure, the objective of achieving 80% of the entire population having access to health facilities by 2005 was not achieved. The Uganda Debt Network has observed that 'not every sub district in Uganda (serving approximately 100,000 people) has a health centre staffed by a doctor with a small theatre for operations such as caesarean sections and hernia repair.'[140]

To reduce discriminatory tendencies in the health sector, there is a need to make reproductive health services accessible to all people in rural areas. Provision should be made for an efficient emergency maternal referral system at the health sub-district level. Village health units should be facilitated to render delivery care services to the women who cannot afford hospitals. To achieve this, the HSSP must consider incentives to train and retain skilled health workers[141] at these hard-to-reach health units. It must also increase efforts to sensitise communities on the value of the delivery care.

d) Empowerment

It is an established fact that not many people know their human rights, including the right to health. How can they take responsibility for safeguarding their human rights if they are not aware of what human rights are, let alone know what they have a right to? A number of people probably think that when a government builds them a hospital, for instance, it is doing them a favour, and not that it is fulfilling its obligation. The HSSP has no provisions for empowering the people to know and claim their human right to health. Knowledge is power. It is what the people want. They should be made aware of the mechanisms available for complaint in case their human rights are violated, including the right to health. There is therefore an urgent need to educate people about their human rights in general and the right to health in particular. Health education needs to be properly streamlined. All the people need to access information on the prevailing health problems and the measures

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[140] Uganda Debt Network (n 3).

[141] The UPPAP II Report highlighted lack of adequate qualified staff generally, mainly doctors, anaesthetic staff and laboratory technicians.

taken to prevent and control them.[142] Health education should also contain information on health activities for parents to help them ensure the proper development of their children. The young people need health education aimed at explaining to them the dangers of alcohol and drug abuse as well as eating disorders.[143] Moreover, health education is found to be one of the most effective tools in the fight against HIV/AIDS.[144]

Until recently, in Uganda health education for adolescents, especially on sexual and reproductive health, has been very restricted. It is traditionally a taboo for parents to talk openly about sex with their children, and young people were normally given little guidance on the subject. Such practices have resulted in a number of problems for the young (including teenage pregnancies that may result in unsafe abortion, early marriages, and street children), all which have adverse implications for the right to health. This lack of sex education affects particularly girls and women, who become vulnerable to violation by men.

The HSSP should not be silent on the curriculum for training health professionals. The curriculum should contain human rights education so that health professionals can know their rights and those of their patients. It is argued that if health professionals know their human rights and those of the patients they will be in a better position to contribute effectively to the promotion of the gradual realisation of the right to health in Uganda.

e) *Linkage to human rights standards*

The HSSP in the Uganda PRSP does not base its health provisions on human rights standards. As such, the monitoring and evaluation data it uses is inaccurate for detecting the likely progress towards full realization of the right to health for all the people. For instance, the HSSP uses mortality rates and identified process indicators such as the immunisation rate; the percentage of health centres with qualified staff; the percentage of health units without stock-outs; and perception of services. It is very important that the government of Uganda makes all efforts to find out whether or not the health strategy benefits the poor and most vulnerable. The monitoring indicators used to measure progress do not measure the impact of the strategy on the poor or on the regions. For instance, the indicators used (e.g. the per capital level and age-specific outpatient department utilization; the percentage of under one-year-old children immunized according to schedule; and the proportion of health centres with minimum staffing norms) do not actually reveal whether the poor and most vulnerable members of society are benefiting from the health strategy or not.

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[142] See Guidelines, UN Doc E/1991/23/ Suppl No 3, p 105; UN Doc E/C 12/ 1994/W, Question 25, p 14.

[143] See the Second Report of the Federal Republic of Germany, UN Doc E/1986/A/Ass 10, para 124.

[144] See Representative of Netherlands, UN Doc E/C 12/1989/SR 15 para 59. The importance of health education for the people was emphasised a long time ago. Sigerist maintains that the French philosophers for example, recommended health education for the people. See HE Sigerist, *Medicine and Human Welfare* (Yale University Press/Oxford University Press, New Haven/London 1941) 80; G Rosen, *A History of Public Health* (Johns Hopkins University Press, Baltimore/London 1993) 109.

The Government needs to set up indicators that will measure the percentage of vulnerable people affected by its health strategy. It should aim at having statistical data on the percentage of the population affected by any health intervention in a final report distributed periodically to all stakeholders. Such a report would provide the basis for policy reform and the improvement of health intervention to improve the health situation of the most vulnerable. But in order to monitor government progress in this direction it is necessary to have a 'right to health unit' or a body that constantly advises, guides and reminds the government and all the development partners of their commitment to the realisation of the right to health in Uganda. The right to health unit that was launched by the Uganda Human Rights Commission in January 2007 is highly commendable and should be supported by the Ugandan government and the international community.

6. The views of the civil society on the right to health in Uganda

Civil society organisations make a great contribution in any development work. They are very innovative in service delivery, building local capacity and can effectively and efficiently advocate for the poor. However, to be able to play this constructive role in society, they need to work hand in hand with the government. But the reality is that the government of Uganda seems to pay little attention to the role of the private sector (profit and non-profit making), who are often the main health providers for the poor. This is shown by the fact that the government provides little finance to the private sector. The CSOs should actively participate in the articulation, design and implementation of health-related programmes in Uganda.

The UNHCO is an example of such a CSO that exhibits quality work in the promotion of the right to health in Uganda. It works with 'patients, healthcare professionals and policymakers to build a system that better responds to the needs of Uganda's people.'[145] It informs the local communities and 'ordinary people of their rights and encourage[s] them to demand the improved services that they deserve.'[146] It reminds the local 'government, hospitals and clinics of their responsibilities to provide value for money healthcare to those whose interests they ought to represent.'[147] The Ugandan government has already tested the partnership with UNHCO and realised the great potential of such partnership. The combined ventures with the government include:

- Carrying out research into patient satisfaction and rights awareness, which has informed the Ministry of Health's Health Sector Strategic Plan II. Listening to feedback from patients is a key component of the Plan and UNHCO has been assigned to conduct a national client satisfaction survey, which is currently underway.

[145]WHO, 'Uganda National Health Users/Consumers' Organisation promotes awareness on the rights of health consumers' <http://www.who.int/patientsafety/news/uganda_health_consumers/en> accessed 6 August 2008.
[146]Ibid.
[147]Ibid.

- Contributing to the Patient's Charter – which protects patients' rights and encourages good patient/provider relations – by educating people about the standard of healthcare that they are entitled to.
- Participating in the national working group on patient safety research.
- Campaigning for more money to be put into health, which has resulted in Parliament making a commitment to address the financing of infant and maternal mortality measures. Parliament will also look into the issues of corruption and inefficiency in drug management in medical stores.[148]

Sometimes the challenging political situation in which CSOs operate becomes a hindrance to their work, because the government may perceive their work to be a threat to its policies. It is a truism that CSOs sometimes act on their own, or in opposition to government ventures, thereby causing tension and conflict. In such a situation, the work of CSOs has a limited impact on public policy and practice. However, it is time to realise that policy engagement can often have a greater impact than contestation and that policy advocacy by CSOs can spur more widespread benefits than their service delivery effort left alone.[149] Research has shown that 'by getting the fundamentals right – assessing the context, engaging policymakers, getting rigorous evidence, working with partners, communicating well, CSOs can overcome key internal obstacles',[150] and thus, contribute to 'making the Uganda health system even more cable, more responsive and more accountable' to the people.[151]

7. Multinational financial institutions and the right to health in Uganda

Based on the legal obligation of its members to respect, protect and fulfil the right to health, the policies of the World Bank ought to foster the progressive realisation of the right to health. However, in Uganda, as we have already seen, funding the Ministry of Health is constrained due to macro-economic concerns of the World Bank and the IMF; yet the World Bank is aware of the interconnectedness between the rights to health, education, and non-discrimination on the basis of gender. According to the study of the World Bank entitled *Engendering Development*:

> Mothers' illiteracy and lack of schooling directly disadvantage their children. Low schooling translates into poor quality of care for children and then higher infant and child mortality and malnutrition. Mothers with more education are more likely to adopt appropriated health-promoting behaviours, such as having young children immunised. Supporting these conclusions are careful analyses of household survey data that account for other factors that might improve care practices and related health outcomes.[152]

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[148]Ibid.
[149]See Julius Court, Enrique Mendizabal, David Osborne and John Young, 'Policy Engagement: How Can Civil Society Organisations be More Effective?', Overseas Development Institute (2006) 1 <http://www.odi.org.uk/Rapid <accessed 4 July 2006>.
[150]See the Executive Summary (n 43).
[151]<http://www.dfid.gov.uk/casestudies/files/africa/uganda-health-rights.asp>.
[152]See World Bank, 'Engendering Development Through Gender Equality in Rights, Resources and Voice' <http://www.worldbank.org/gender/pn/englishversion.htm> accessed 22 December 2005.

Sometimes the policies of the World Bank and IMF cause a shortage of funds in other areas that are determinants of the right to health, such as the education, clean water, sanitation and adequate housing, in which case these policies lead to a violation of the right to health.

Also by supporting the Uganda PRSP which does not treat health as a human right, the World Bank and IMF do not encourage the further development of the right to health in Uganda. They ought to constructively criticise and influence the redesign of the PRSP to better articulate the right to health concerns.

However, some critics argue that the 'decision to fix a budget ceiling in Uganda is mainly political.' They maintain that the 'perceived influence of the international financing institutions cannot be proven in Uganda.' But they agree that these financial institutions support this policy (of a budget ceiling).[153] There is great need for these institutions to look beyond macroeconomic stability. The IMF should allow an increase in concessional aid, in the form of grants that can have little impact on the macro-economy of the country.

Although the IMF is already supporting the call for donors to meet 0.7% of their gross domestic product and provision of aid over the long term, it should provide analyses of how much additional aid could be absorbed by a low income country such as Uganda, before upsetting the macro-economy of such a country. Otherwise, increased funding to the health sector should be a priority if the right to health is to be promoted in Uganda.[154]

The international trade practices of pharmaceutical companies may have an adverse effect on the realisation of the right to health in Uganda. This is more so when these companies value market perspectives that regard health care as a commodity to be sold like any other good and not as a public good to be distributed to all, including the poor and most vulnerable.

8. The way forward

Uganda, like any other state, is obliged 'to adopt legislation and to take other measures to assure that the health care providers do not disadvantage or exclude individuals or groups'.[155] Uganda must design a comprehensive strategy to meet the obligation to fulfil the right to health. It is not enough, for instance, to arrest and imprison drug dealers without a proper education programme for the youth and the general public about the dangers of using drugs. Toebes argues, based on Watkins et al,[156] that the US authorities violated an obligation to fulfil the right to health when they failed to respond adequately to an outbreak of cocaine use in the US by mounting a national health campaign to counteract drug-related morbidity and

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[153]See Dr John Odaga and Dr Peter Lochoro, 'Budget Ceilings and Health in Uganda' (Caritas Uganda January 2006) iii.

[154]The Commission for Macro-economics and Health 2001 recommended an increased flow of donor aid to low income countries, in a sustained, well-targeted, efficient, equitable and transparent manner.

[155]See Toebes (n 92) 328.

[156]BX Watkins, RE Fullilove and M Thompson Fullilove, 'Arms against Illness: Crack Cocaine and Drug Policy in the United States' (1998) 2(4) Health and Human Rights 48–58.

mortality, but only imprisoned drug users which inter alia led to increased cases of HIV/AIDS in the prisons.[157]

Under the obligation to 'fulfil', Uganda should 'take measures necessary to ensure that each person within its jurisdiction has opportunities to obtain satisfaction of those needs, recognized in the human rights instruments, which cannot be secured by personal efforts.'[158] Uganda may implement this obligation 'progressively' and to the maximum of its resources.[159] This means an obligation to progressively improve the level of healthcare facilities, such as dispensaries, clinics, hospital transport and services. It involves taking concrete and immediate steps to improve the healthcare infrastructure in Uganda.

From a human rights perspective, the basic essentials of the right to health entail the following elements, according to the WHO: primary healthcare, which includes at least education concerning health problems and the methods of preventing and controlling them; the promotion of food supply and proper nutrition; the adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunisation against the major infectious diseases; the appropriate treatment of common diseases and injuries; and the provision of essential drugs.[160]

In providing these healthcare services to people, the principle of non-discrimination must be upheld.[161] That is, there must be equal access to health services by vulnerable groups, and the services ought to be sufficiently available and their quality has to be considered. Thus, the doctors and nurses must be skilled;[162] and the equipment and drugs must be adequate for all the people in Uganda.[163] Failure to ensure access to safe and adequate drinking water in villages across the country; failure to provide family planning and pregnancy-related services to all women (article 12 CEDAW) all constitute a violation of the right to health of the people.

Measures to promote a healthy environment include those that conserve natural reserves, prevent deforestation and clean up chemical dumps.[164] This is in line with the provisions of paragraph 2(b) of article 12, namely that 'States parties have to improve all aspects of environmental and industrial issues that affect human health.'

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[157]See Toebes (n 92) 334.

[158]Ibid at 332.

[159]See Article 2(1) ICESCR.

[160]See World Health Organisation, Declaration of Alma-Ata on 'Health for All and Primary Healthcare Strategies' International Conference on Primary HealthCare, Alma-Ata, USSR, 6–12 September 1978 (WHO, Geneva 1978). It is important to note that 'definitions of the core and/or supplemental contents of the civil and political rights are being shaped continually. The search for similar clarity with respect to economic, social and cultural rights will continue to rapidly advance' See S Leckie, 'Violations of Economic, Social and Cultural Rights', in TC van Boven, C Flinterman and I Westendorp (eds) *The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights* (SIM, Utrech: 1998) 35–86 (SIM-Special 20) at 60. The same message is quoted by Toebes (n 92) 288.

[161]See ICESCR articles 2 and 3, CEDAW articles 1 and 2.

[162]Guidelines (n 142), indicators 4(f)–(h): 'Proportions of Population/Pregnant Women/ Infants having Access to Trained Personnel for Care.'

[163]See UN Doc E/C 12/1995/SR.14, para 55; UN Doc E/1986/4/Add 9, p 9; UN Doc.E/ 1990/5/Add 13, para 107.

[164]See Second Report of Canada, UN Doc E/1990/6/ADD 3, para 23.

The positive political will of the government of Uganda to tackle these issues and promote the right to health must be recognised. In a speech at the Opening of the 4th Conference of African National Human Rights Institutions, the President of Uganda stated clearly that he is fully aware that in Uganda, as in other countries, the realisation of the right to health has to be developed further.[165] The government of Uganda has often reiterated its commitment to truly advance human rights and development through the promotion of good governance and the rule of law. A significant measure in this respect is the implementation of the 2005–2010 Health Sector Strategic Plan II, which seeks to reduce morbidity and mortality from major causes of ill health through universal delivery of the Uganda National Minimum Health Care Package (UNMHCP).

However, there is still the need to set clear timeframes within which to realise the right to health and also to set health-related indicators and measurable targets that help evaluate the progress made towards realisation of this right.[166] The right to health indicators can be considered as the 'quantitative or qualitative abstracts of information that can be used to describe' the right to health situation and context and to measure the changes or trends in the enjoyment of this human right over time.[167]

According to the UN Special Rapporteur on the Right to Health, Uganda must invest in human resources for health if it is to bring about the progressive realisation of the right to health. It must devise proper means to train and retain health professionals as an effective and efficient solution to the devastating problem of 'skill drain' to the health sector in Uganda.[168]

The Government of Uganda, through the Ministry of Finance, Planning and Economic Development, in collaboration with the Ministry of Health, and other development partners, should design a National Policy Framework that views health from a human rights perspective, in the general context of the Uganda Poverty Eradication Action Plan. Particularly, the Ministry of Finance, Planning and Economic Development should increase budgetary allocations to the Ministry of Health, to effectively improve the terms and condition of health workers, especially of those working in rural and remote areas. This motivational strategy could include provision of better accommodation with good facilities for healthcare workers; increased salaries; and the timely payment of healthcare workers, as

[165]See Speech by His Excellence, Yoweri Museveni, at the Opening of the 4th Conference of African National Human Rights Institutions, Kampala: Uganda, 14 August 2002, 8 <http://www.nhr.net/pdf/African4thNhri> accessed 19 November 2005.

[166]See Commissioners John Mary Waligo et al (eds) *Your Rights: The Magazine that Promotes Human Dignity* (Kampala 2005) 5 <http://www.uhrc.org> accessed 20 November 2005.

[167]See B Andersassen and Hans-Otto Sano, 'What's the Goal? What is the Purpose/ Observations on Human Rights Impact Assessment' (Norwegian Centre for Human Rights, University of Oslo, Norway, February 2004) 15.

[168]The human rights approach to the right to health demands, as expressed by the UN Special Rapporteur on the Right to Health, that the solution to the problem of 'skill drain must be locally determined, with meaningful, active and informed participation of representatives of poor and rural communities, health – care workers and civil society.' See his guiding principles on this issue, UN Doc A/60/348, 17.

recommended by the Uganda Human Rights Commission research on health rights.[169]

The health system must have a greater focus on the disadvantaged, the most vulnerable in society and those living in poverty. There is also need for an effective national health law to regulate the importation and distribution of medical equipment, the sale of drugs, the relationship between health care providers and patients, patient admission and administration procedures, pharmaceutical companies, etc.

9. Conclusion

The right to health entitles people to the freedom of making decisions about their health and treatment. It also entitles them to a system that protects their health through offering them equal opportunity to access healthcare services and other determinants of health such as safe and clean drinking water. The right to health obliges governments to take concrete and timely measures to prevent, treat, and control both communicable and non-communicable diseases, including neglected diseases.[170] The right to health also includes a right to maternal, child and reproductive health. It includes a right to a threat-free natural environment and a healthy work place. It is, however, inseparable from other important human rights, such as the right to education.

Probably the most effective and efficient way to bring about the progressive realisation of the right to health is through a human rights-based approach to health; an approach that pays particular attention to the principles of participation, accountability, non-discrimination, equity and recognition of national and international legal provisions of the right to health. It calls for an analysis of the design, implementation, and evaluation of healthcare programmes in a participatory and transparent manner.

This article has reviewed the programmes and measures taken by the Government of Uganda to implement a human rights-based approach to the right to health. It has recognised several areas in which progress has been achieved and outlined other areas in which further improvement is necessary.

At the same time, the article has highlighted the important role of international assistance and co-operation in a spirit of 'shared responsibility'. Thus, all Uganda's

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[169]See Waliggo (n 166). The research recommended the following to the Ministry of Health: Increased salaries to health workers in order to check on rampant corruption. Maintain constant and timely drugs in all health facilities. Provide cost–effective running water (spring protection, harvesting rainwater and boreholes). Provide a balanced diet for patients to enhance their body immunities. Provision of electricity and laboratory services to rural health units. Construction and the expansion of some health Units, to solve the problem of congestion. Secure ambulance services to transport referral cases. Employment of more trained staff to all health facilities and the staff should have chances for refresher courses. To give priority to the needs of vulnerable groups, like, PLHA, PWDs, children, and poor pregnant women. However, I think a human rights-based approach to the right to health better summarises these recommendations.

[170]Two categories of neglected diseases have been identified so far. The first one is that of endemic, chronic and disabling diseases such as leprosy, soil transmitted helminths, lymphatic filariasis and onchocerciasis. The second one is that of growing epidemic deadly diseases such as Buruli Ulcer, Chagas, Leishmaniasis and African Trypanosomiasis/ sleeping sickness (locally known as 'Emongota' in Lusoga and Luganda).

development partners need to ensure that international trade agreement and humanitarian assistance programmes serve to promote respect for the right to health.

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