HUMAN RIGHTS-BASED ACCOUNTABILITY FOR HEALTHCARE IN UGANDA

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ABSTRACT

The promotion of the right to the health of the people involves, among other things, the eradication of injustices such as the discrimination and stigmatization of patients by health services providers. This article argues that a human rights-based accountability promotes health as a human right proper to every human being, for which all duty-bearers must be held accountable. It establishes that progress lies in enabling people to have a say in the matters of their health, and in demanding that they be treated with dignity and respect for all their rights. It is shown that the rights-based accountability for health calls for design and implementation of health-related programmes that reflect ten key principles of a right to health analytical framework. These include: (a) the recognition of the international, regional and national human rights laws, norms and standards; (b) Resource constraints and progressive realization; (c) Obligation of Immediate Effect; (d) Freedoms and Entitlements; (e) Available, Accessible, Acceptable and Quality; (f) Respect, Protect and Fulfil; (g) Non-discrimination, Equality and Vulnerability; (h) accountability; (i) Active and Informed Participation; and (j) Empowerment and International Assistance and Cooperation.

I. INTRODUCTION

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

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

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.'[2] Thus, the right to health means a right to a functioning, effective and integrated health system, which encompasses healthcare and other determinants of health.[3] Good health increases the productivity of the population, which is essential for economic development and stability of the nation.[4]

This article argues that the promotion of the right to health of the people involves more that than provision of medical facilities, prevention, and treatment of ailments. It involves addressing the injustices such as discrimination, stigmatization and abuse of patients by health service providers. The most victims of such abuses are vulnerable members of society in Uganda, such as women, children, lepers and all the victims of neglected diseases. To promote this right to health of the people, it is incumbent on all the duty-holders to design and implement health-related programmes using at least ten key principles of a right to health analytical framework. These include among others: (a) the recognition of the international, regional and national human rights laws, norms and standards; (b) Obligations under the right to health; (c) Resource constraints and progressive realization; (d) Freedoms and Entitlements; (e) Available, Accessible, Acceptable and Quality; (f) Non-discrimination, Equality and Vulnerability; (g) Accountability; (h) Active and Informed Participation; and (i) Empowerment; and International Assistance and Cooperation.

From 1986 to 1993, the current Ugandan Government under President Yoweri Museveni began a period of rehabilitation and reconstruction of the country. 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 the time.[5] No wonder, therefore, that numerous vertical programmes were created by various donors to fill the policy vacuum. For instance, the United Nations Children's Fund (UNICEF) had child survival programmes; USAID had family planning; DANIDA—essential drugs; and the World Bank—physical rehabilitation. At this stage, health in Uganda was not treated from a human rights

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2. *See,* the Opening text of the WHO Constitution (1946).

3. *See,* A.H. Khan, *Health and Human Rights, in* DAILY STAR, Thursday December 20, 2007.

4. 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 in id.*

5. *See,* J. MACRAE, AIDING RECOVERY: THE CRISIS OF AID IN CHRONIC POLITICAL EMERGENCES (2001).

perspective either by the Government or by the donors. In fact, even though Uganda's Poverty Reduction Strategic Plan (PRSP) recognizes 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 right to health analytical framework to promote health, and not all its policies are fully pro-poor in the true sense of the word.

II. DEFINITION OF HUMAN RIGHTS-BASED ACCOUNTABILITY

A human rights-based accountability for health can refer to a 'process which requires government to explain and justify how it has discharged its obligations regarding the right to health.'[6] It is also an opportunity for the rights-holders 'to understand how the government and other duty-holders have discharged their right to health obligations.'[7] It calls for identification of human rights obligations of all duty-holders in the health sector and making use of the human rights law[8] to advance the right to health of all the people in Uganda. It does not seek to punish duty-holders for the violation of the right but redress in view of improving performance to promote the right to health. It is motivated by a conviction that 'giving people a say in their own future, and demanding that they be treated with dignity and respect for their rights is the way to make progress.'[9]

III. THE TEN KEY RIGHT TO HEALTH ANALYTICAL FRAMEWORK

A. Human Rights Laws on the Right to Health

Uganda is signatory to a number of international and regional human rights treaties that give rise to the legal basis of the right to health. The human rights obligation to promote the right to health of all people in Uganda stem from these international and regional human rights instruments. These instruments ought to guide Uganda in its legislation and policy on the right to health.

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6. *See*, H. POTTS, ACCOUNTABILITY AND THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH 13 (2007).

7. *Id.*, at 4-5.

8. *See*, Toebes Brigit, *Human Rights and Health Sector Corruption*, *in* GLOBAL HEALTH AND HUMAN RIGHTS: LEGAL AND PHILOSOPHICAL PERSPECTIVES (J. Harrington et al, 2009).

9. *See*, IRENE KHAN, THE UNHEARD TRUTH: POVERTY AND HUMAN RIGHTS 5 (2009).

1. International Human Rights Laws.—These include the International Covenant on Economic, Social and Cultural Rights;[10] the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment;[11] the UN Convention on the Rights of the Child;[12] the International Convention on the Elimination of All Forms of Discrimination against Women;[13] the International Convention on the Elimination of All Forms of Racial Discrimination;[14] and the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families.[15]

2. Regional Human Rights Instruments.—These instruments include the African Charter on Human and Peoples' Rights;[16] the African Charter on the Rights and Welfare of the Child;[17] and the Protocol to the African Charter on the Rights and Welfare of Women.[18] Other regional instruments which recognize the right to health, but to which Uganda is not a signatory, include the European Social Charter,[19] and the Additional Protocol to the American Human Rights in the Area of Economic, Social and Cultural Rights.[20]

However, of all the human rights instruments, it is the ICESCR in particular which articulates most broadly the legal foundation of the right to health by providing

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10. Adopted and opened for signature, ratification and accession by the General Assembly resolution 2200A (XXI) of 16 December 1966; entry into force 3 January 1976, in accordance with article 27; hereinafter ICESCR.

11. Adopted by the UN General Assembly on 10 December 1984 (resolution39/46); entered into force on 26 June 1987; hereinafter CAT.

12. Adopted and opened for signature, ratification and accession by the UN General Assembly resolution 44/25 of 20 November 1089; entry into force 2 September 1990, in accordance with article 49; hereinafter CRC, art. 24.

13. Adopted in 1979 by the General Assembly, hereinafter CEDAW, art 11(1) (f) and 12.

14. Adopted and opened for signature and ratification by the General Assembly resolution 2106 (XX) of 21 December 1965; entry into force by 4 January 1969, in accordance with article 19; hereinafter ICERD, art. 5(e)(iv).

15. Adopted by the General Assembly resolution45/153 of 18 December 1990, art. 28.

16. Adopted June 27, 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M.58 (1982), entered into force October 21, 1986, art. 16.

17. OAU Doc. CAB/LEG/24.9/49 (1990), entered into force Nov. 29, 1999, art. 14.

18. Protocol of 2003, art. 14.

19. Council of Europe treaty, adopted in Turin on 18 October 1961 and revised 1996. The revised Charter came into force in 1999 and is gradually replacing the initial 1961 treaty. *See* art. 11 (Revised).

20. Protocol of San Salvador, O.A.S. Treaty Series No. 69 (1988), signed November 17, 1988, *reprinted in* Basic Documents Pertaining to Human Rights in the Inter-American System, OEA/Ser.L. V/II.82 doc.6 rev. 1 art 67 (1992), art. 10.

that everyone has the right 'to the enjoyment of the highest attainable standard of physical and mental health.'[21] However, the scope and meaning of the right to health has been clearly explained by the Committee on Economic, Social and Cultural Rights that oversees the implementation of the ICESCR.[22] While in its General Comment No. 3 the Committee reiterates the state parties' core obligation to ensure the satisfaction of minimum essential levels of each of the right enunciated in the Covenant, it leaves the minimum essential level of each right to the discretion of the incumbent state party;[23] although the Alma-Ata Declaration described as essential 'primary healthcare' for the right to health.[24]

3. The Ugandan National Legal Framework.—The supreme law of Uganda expressly provides for the protection and promotion of human rights of all peoples.[25] Accordingly, Uganda is required to take all practical measures to ensure the provision of basic medical services to the entire population, and also to promote access to the underlying determinants of health such as food, water, shelter and proper sanitation.[26]

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

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21. *See*, art. 12.

22. *See*, General Comment 14, adopted in May, 2000. The Committee on Economic, Social and Cultural Rights publishes its interpretation of the content of human rights provisions in the form of General Comments on thematic issues. Although these general comments are not legally binding documents, they offer authoritative interpretation of the meaning and content of a particular right for the benefits of the States parties to the ICESCR, in order to assist them implement the covenant; and to help the States parties in fulfilling their reporting obligations. *See*, The Purpose of General Comments, U.N. Doc. E/1989/22, Annex III (1989), at 87, *reprinted in* Compilation of General Comments and General Recommendations, *adopted by* Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.6 (2003), at 8. *See also*, Fact Sheet No. 16 (Rev.1): Committee on Economic, Social and Cultural Rights, available at <http://www.unhchr.ch/html/menu6/2/fw16.htm#5>.

23. *See*, General Comment No. 3, ¶ 10.

24. *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 recognized in other international and regional human rights instruments as above.

25. *See*, UGANDA CONST. (1995), arts 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).

26. *See id*., Preamble, ¶¶ XX (on medical services), XXI (on clean and safe water), and XXII (on food security and nutrition).

benefits.'[27] However, as noted by the Uganda Human Rights Commission (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 provisions of the Constitution.

Consequently, 'the right to health is neither appreciated nor understood within the medical and legal circles.'[28] It is not therefore surprising that there appears 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 actualize the constitutional provisions on the right to health, the Constitution of Uganda and the Local Governments Act[29] downsized, restructured and decentralized the services of the Ministry of Health (MoH). Responsibility and authority for delivery of health services were 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 mobilization.[30] The intention of the SWAP is to promote transparency, ease securing funds needed for capacity building, and decision-making procurement based on priorities.[31]

While the Constitution of Uganda and the Local Governments Act 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 any enforcement mechanism. 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.'[32] 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.[33] However, the

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27. *See*, National Objectives and Directive Principles of State Policy, objective XIV(b).

28. *See*, UGANDA HUMAN RIGHTS COMMISSION (UHRC), THE VOICE OF PATIENTS: THE STATE OF THE RIGHTS OF PATIENTS AND THEIR ATTENDANTS IN UGANDA (2005), at x.

29. Cap. 243.

30. *See*, MINISTRY OF HEALTH, REPORT OF UGANDA HEALTH FACILITIES SURVEY (UHFS) 1 (2000).

31. *Id.*

32. *See*, MINISTRY OF HEALTH, NATIONAL HEALTH POLICY (1999), § 13, available online at <http://www.health.go.ug/docs/NationalHealthPolicy.pdf> (accessed on December 28, 2007).

33. *See id.* 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

Government of Uganda has not accomplished much. 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 lack of a clear legal framework. While it is its responsibility to control the procurement and distribution of drugs in Uganda, the National Drug Authority (NDA) is not effective in controlling the sale and buying 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 under dose, as the case may be. This has led to increased antibiotic resistant bacteria in Uganda.

In a 2005 newspaper article, one Kibuuka reported the confiscation of 500 containers of fake drugs by Phoebe Mukasa, the District Drug Inspector.[34] 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. It is also common for people to buy strong drugs freely from the clinics. There is therefore, probably, 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 relating to various aspects of health such as epidemic diseases like ebola, the prevention of malaria, eye surgery, quality of food, women and children's health, etc require legal regulation. Similarly, laws that deal directly with the rights of patients are urgently required.[35]

4. Other Jurisdictions.—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 clearly recognizes the right to health. It reads:

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organizations, (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) stigmatization and denial due to ill health or incapacity.

34. *See*, L. Kibuuka, *Drugs Authority Raids Fake Shops in Kayunga*, THE NEW VISION, December 10, 2005.

35. *See*, MINISTRY OF HEALTH, HUMAN RESOURCES FOR NATIONAL HEALTH POLICY (2006), available online at <http://www.health.go.ug/docs/HRH_Policy_Final.pdf> (accessed December 28, 2007). The Policy 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 rights.

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

b. The State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.

c. 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 victims whose rights have been violated to be defended in the courts of law. Already, the South African Constitutional Court has recorded at least two cases on the right to health.[36] In the *Soobramoney* case,[37] 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. Unfortunately, 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 both political level in fixing the health budget, and, functional level in deciding upon priorities to be met.[38] It, however, 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. Consequently, 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.

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36. *See*, *Soobramoney v. Minister of Health Kwazulu-Natal*, Const. Court of South Africa, Case CCT 32/97; and *Minister of Health v. Treatment Action Campaign*, available at <www.concourt.gov.za> (accessed October 20, 2007).

37. *Id.*

38. *Id.*

In *Dina Rosa Vieira v. Municipality of Porto Alegre*,[39] 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 healthcare guaranteed in the Brazilian Constitution. The Tribunal ordered the State to provide all treatment needed by the plaintiff.[40]

In *Choose v. Byrne*,[41] 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 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.'[42]

The European Court of Human Rights has given a ruling on non-interference with information related to family planning services and pre-and postnatal care. In *Open Door and Dublin Well Women v. Ireland*,[43] the European Court of Human rights ruled that there had been an interference with the right of the applicant counselors 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 article 10 of ECHR.[44] 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. Why should Uganda be an exception?

5. The Role of the UN Special Rapporteur.—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.[45] These reports offer a viable source of law and

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39. Decision No. RE-271286.

40. *Id.*

41. Supreme Court of New Jersey, 91 N.J. 287; 450 A. 2d 925, 18 August 1982.

42. *Id.*

43. *See*, ECHR, judgment of 29 October 1992, A.246.

44. *Id. See* also, *The Right to Know, Human Rights and Access to Reproductive Health Information, in* ARTICLE 19 (S. Coliver ed., 1995), at 329.

45. 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

guidance on the practical implementation of the right to health.[46] For instance, in his report from the Ugandan Mission, 17-25 March 2005, on the issue of neglected disease, 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 information and education for all people, on the prevention and health promoting behaviour, as well as on how to access health services;[47] the right of individuals and communities to informed and active participation in health decision-making which affect them[48] (which Uganda encourages in the Preamble of its Constitution [Article II(i)] and promotes in practice through involving civil society organizations in the preparation of Uganda's PRSP/PEAP[49] and through its new policy on decentralization in the health sector);[50] 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 of 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.[51]

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to health information from all relevant sources; dialogue and discuss possible areas of cooperation with relevant actors, including governments, relevant United Nations bodies, specialized agencies and programmes, in particular the WHO, and the Joint United Nations Programme on HIV/AIDS, as well as non-governmental organizations, 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.

46. 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 Organization, 16-23 July 2003 and 27-28 August 2003, see E/CN.4/49/Add.1.

47. *See*, E/CN.4/2006/48.Add.2, ¶¶ 33 and 34.

48. *See*, E/CN.4/2006/48.Add2, ¶ 36.

49. *See*, PEAP 2000, summary and objectives, at 12; PRSP, Resource Allocation to the Health Sector in Uganda, Paper No. 7, 2004, at 16.

50. *See*, Village Health Committees (Health Centres I to IV), in the HSSP of Uganda's PRSP.

51. *See*, Report of the Special Rapporteur on the Right to Health Mission to Uganda, 17-25 March 2005 (E/CN.4/2006/48/Add.2) ¶ 54.

B. Uganda's Legal Obligations under the Right to Health

Like any other State that has ratified these binding international human rights instruments, Uganda has an obligation to ensure the right of every one to the enjoyment of the highest attainable standard of health.[52] There are mainly three types of obligations for Uganda under these instruments. These are: 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;[53] 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;[54] and fulfilment, for instance, by taking positive and effective measures to facilitate the progressive realization 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.[55] In a way, and according to Toebes, the obligation to respect is a 'negative obligation' for the State.[56] 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.[57]

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

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52. UN Doc. A/60/348, at 7.

53. 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 Human Rights Commission Reports.

54. 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.

55. *See*, Bothe Michael, *Les Concepts Fondamentaux du Droit à la Santé: Le Point de Vue Juridique, in* LE DROIT À LA SANTÉ EN TANT QUE DROIT DE L'HOMME (René-Jean Dupuy ed., 1979), at 14.

56. *See*, C.A.B. TOEBES, THE RIGHT TO HEALTH AS A HUMAN RIGHT IN INTERNATIONAL LAW 312 (1999).

57. *See*, A. EIDE, THE NEW INTERNATIONAL ECONOMIC ORDER AND THE PROMOTION OF HUMAN RIGHTS (1987), UN Doc.E/CN.4/Sub.2/1987/23, July 1987, § 67.

and physical integrity.'[58] 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 unprivileged areas,[59] respect for equal access to family planning services and pre and postnatal care, respect for equal access to water and sanitation, abstention from environmental and industrial policies detrimental to health, abstention from traditional practices detrimental to health and information on such practices, non-interference with the provision of healthcare, healthcare related services, such as water and sanitation, or information on water and sanitation and non-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 equally access safe and portable water, adequate sanitation, a healthy environment, health education, adequate supply of food, nutrition, and adequate housing. The obligations to protect and to fulfil are of a positive nature. Both require the Uganda Government to take certain measures to protect and assist its people realize their rights. 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.'[60] Hoof Van is more specific when he argues that the obligation to protect means 'to take steps—through legislation or otherwise—which prevent or prohibit others (third persons) from violating recognized rights or freedoms.'[61] 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

58. TOEBES, *supra* note 56, at 313.

59. 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, *supra* note 56, at 116.

60. EIDE, *supra* note 57.

61. *See*, G.J.H. Van Hoof & K.D.V. Mestdagh, *Mechanisms of International Supervision*, *in* SUPERVISORY MECHANISMS IN INTERNATIONAL ECONOMIC ORGANIZATIONS (P. Van Dijk ed., 1984), at 106. *See also*, Article 12 of the ICESCR; General Comment No. 3, 1990, ¶¶ 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, ¶¶ 17 and 18.

the accessibility of the healthcare services provided.[62]

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.[63] The following sum up the core legal obligations of Uganda's right to health, according to General Comment No.14:

(a) 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) obligation to ensure access to the minimum essential food which is nutritiously adequate and safe, to ensure freedom from hunger to everyone;
(c) obligation to censure access to basic shelter, housing and sanitation, and an adequate supply of safe and clean water;
(d) obligation to provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
(e) obligation to ensure equitable distribution of all health facilities, goods and services; and
(f) 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.[64]

It is Uganda's legal obligation to establish an integrated health system responsive to local priorities, according to the report on the Uganda Mission by the UN Special Rapporteur on the right to health.[65] Such a system should be flexible enough

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62. TOEBES, *supra* note 56, at 328.

63. *See*, CORE OBLIGATIONS: BUILDING A FRAMEWORK FOR ECONOMIC, SOCIAL AND CULTURAL RIGHTS (Chapman and Russell eds., 2002), especially the different articles on the minimum core obligations under each of the rights recognized in the Covenant. *See also*, D. Bilchiz, *Giving Social-Economic Rights Teeth: The Minimum Core and its Importance*, 118 S. AFR. L. J. (2002), at 484 (defending the principle of minimum core obligation based on the moral principles of priority and basic needs).

64. *See*, General Comment No.14, ¶ 43.

65. *See*, Report of the Special Rapporteur, *supra* note 51, ¶¶ 55, 59.

to cater for neglected diseases, outbreaks of communicable diseases (e.g. HIV/AIDS, tuberculosis, and malaria).

C. Resource Constraints and Progressive Realization of the Right to Health

It is true that the right to health cannot be realized immediately and overnight because of resource constraints and time needed to put the infrastructure in place. However, the progressive realization principle in the ICESCR recognizes the limits of availability of resources. The ICESCR cannot 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 well-being 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. General Comment No. 14 stresses the same.[66]

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 Human Rights Commission is particularly important for it sets out a framework for considering health indicators from a human rights perspective. 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.[67]

D. 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.[68] Nevertheless, other states have an international obligation under articles 55

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66. *See*, General Comment No.14, ¶¶ 57-58.

67. *See*, Reports of the Special Rapporteur on the Right to Health to the General Assembly (2003) A/58/427; (2004) A/59/422; and to the Commission on Human Rights (2006) E/CN.4/2006/48.

68. See, P. Hunt, *Using Rights as a Shield, in* 6 HUM. RTS L. & PRACTICE (2002) (encouraging developing countries to use the Covenant to demand international assistance from the developed States). *See also*, O. FERRAZ & J. MESQUITA, THE RIGHT TO HEALTH AND THE MILLENNIUM DEVELOPMENT GOALS IN DEVELOPING COUNTRIES: A RIGHT TO INTERNATIONAL ASSISTANCE AND COOPERATION 12 (2006); S. SKOGLY, BEYOND NATIONAL BORDERS: STATES' HUMAN RIGHTS OBLIGATIONS IN INTERNATIONAL COOPERATION (2006), at 17-18 (observing that although the debate on whether there is a right to

and 56 of the UN Charter, to cooperate in the development and realization of all human rights.[69] 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 puts that request to them. 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).[70] What if those other countries also have resource constraints and hence may not be in 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.[71]

The donor community deserves credit for supporting Uganda's health sector. The Health Policy Statement 2003/04 acknowledged that donors contributed 81 per cent 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.'[72] According

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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).

69. For more detailed information on extra-territorial, trans-boarder or trans-national obligations, see S. Skogly, *The Obligation of International Assistance and Cooperation in the International Covenant on Economic, Social and Cultural Rights, in* HUMAN RIGHTS AND CRIMINAL JUSTICE FOR THE DOWNTRODDEN: ESSAYS IN HONOUR OF EIDE (Morten Bergsmo ed., 2003); R. Künnemann, *Extraterritorial Application of the International Covenant on Economic, Social and Cultural Rights, in* EXTRATERRITORIAL APPLICATION OF HUMAN RIGHTS TREATIES (F. Coomans & M.T. Kamminga eds, 2004); Magdalena Sepulveda, *The Nature of the Obligations under the International Covenant on Economic, Social and Cultural Rights*, INTERSENTIA (2003); and Koen De Feyter, *World Development Law*, INTERSENTIA (2001).

70. General Comment 14, ¶ 39 concludes: "… 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 that 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."

71. *See*, D. Lyons, *The Correlativity of Rights and Duties*, 4 NÔUS (1970), at 44-55. If the recipient countries have a right to international assistance and cooperation, then the more developed nations have a corresponding duty.

72. *See*, Report of the Special Rapporteur, *supra* note 51, ¶ 74.

to the Health Sector Strategic Plan, US $28 per person per year is needed to finance Uganda's national minimum health care package. This is too 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.[73] 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.[74] No wonder a UN report described Uganda as 'a basket case in chronic under-financing of the health sector.'[75] This under-funding of the health sector stifles the HSSP priorities, including reproductive services, human resources and health infrastructure.

E. Freedoms and Entitlements

Like other human rights, the right to health contains the freedom to make decisions about one's own health'[76] including the right to consent before medical treatment and the right not to be discriminated against. It contains entitlements that include the existence of 'a health system protection,'[77] which provides a minimum level of access to water and sanitation, and health care.

F. Available, Accessible, Acceptable and Quality

The right to health analytical framework requires that all health care services, goods and facilities be made available, accessible and culturally responsive to the health needs of the people concerned. In most African countries, including Uganda, information on sexual and reproductive health is largely unavailable. Hunt et al have explained that it is the practice in many countries for sexual and reproductive services to be 'geographically inaccessible to communities living in rural areas, or it is provided in a form that is not culturally acceptable to indigenous peoples and other non-dominant groups.'[78] Accessibility and the cost of health care services may be an issue in

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73. *See*, WHO, REPORT OF THE COMMISSION ON MACROECONOMICS AND HEALTH (2001), ¶ 16.

74. *Id.*

75. OFFICE OF THE UN RESIDENT COORDINATOR, UGANDA: PROMISE, PERFORMANCE AND CHALLENGES: ATTAINING THE PEAP AND MDGS 50 (2003).

76. *See*, POTTS, *supra* note 6, at 4.

77. *Id.*

78. *See*, Paul Hunt et al, *The Right to the Highest Attainable Standard of Health, in* OXFORD TEXTBOOK OF PUBLIC HEALTH (R. Detel et al eds, 2009), at 344.

determining the extent to which women in poor conditions can seek care.[79] It is also true that the quality and outcome of care can influence women's decision whether or no to seek it. Therefore, all the conditions are vital in tackling maternal and infant mortality and in the general promotion of the right to health.

G. Non-discrimination, Equality and Vulnerability

The right to health analytical framework is particular on the issue of non-discrimination, equality and vulnerability. All policies, programmes and projects that aim for the right to health must avoid discriminatory tendencies. As Hunt et al have pointed out, 'stigmatization and discrimination heighten people's vulnerability to ill health.'[80] In the absence of accurate information about a disease, myths, misconceptions and fears may accrue around victims who eventually shun 'diagnosis, delay in seeking treatment and hide the diseases from the family, employers and the community at large.'[81] Victims of neglected diseases can end up becoming physically disabled. There are socioeconomic consequences for the victims of discrimination and stigmatization, which the WHO has indicated, may include ostracism, rejection and abandonment.[82] A study carried out by Coreil et al concluded that women disfigured by lymphatic filariasis sometimes experience more social discrimination than men.[83] The state has a duty to ensure that there are health-related laws and policies to fight discrimination and unequal treatment.

H. Active and Informed Participation

The right to health analytical framework requires that all stakeholders in health matters be given a chance to participate actively and in an informed manner in all health policy-making processes. The right to participation is recognized in international human rights law as one of the core human rights principles.[84] Hunt et al have argued that 'while it

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79. UNITED NATIONS MILLENNIUM PROJECT, WHO'S GOT THE POWER? REPORT OF THE TASK FORCE ON CHILD HEALTH AND MATERNAL HEALTH (2005).

80. *See*, *supra* note 78, at 9.

81. *Id.*

82. *See*, WHO, A HUMAN RIGHTS APPROACH TO TUBERCULOSIS 12 (2001).

83. *See*, COREIL ET AL, SUPPORT GROUPS FOR WOMEN WITH LYMPHATIC FILARIASIS IN HAITI 42 (2003).

84. *See*, Article 25 of the International Covenant on Civil and Political Rights; General Comment 25; Articles 8 (on Freedom of Association), 13 (on Education), and 15 (on Cultural Life) of the International Covenant on Economic Social and Cultural Rights. The 1986 UN Right to Development and

is not suggested that affected communities should participate in all the technical deliberations that underline policy formulation, their participation can help to avoid some of the top-down, technocratic tendencies often associated with old-style development plans and policy implementation.'[85]

Participation builds people's capacity to demand their rights and positively influences the enjoyment of the right to health.[86] Provisions must be made to sensitize the masses and enlist their support. Village health teams in Uganda are a good example of effective participation in the promotion of the right to health. The teams are formed by villagers who receive basic training and are deployed to help in the identification of local health needs and form grassroots delivery mechanisms, including giving advice and the administration of medicine where possible. However, the government must provide resources and support to these vehicles in order to ensure effective participation.[87] Front Line (the International Foundation for the Protection of Human Rights Defenders) argues that:

> [i]ndividuals, groups and communities hold a human right to be involved in decision-making, planning and implementation processes affecting their ESCR and are entitled to information that enables the decision-making process to be meaningful. It follows that states and non-state actors, particularly development agencies have a duty to enable people affected by a development activity to participate in ways capable of transforming their social, political and economic conditions.[88]

I. Empowerment

The outcome of empowerment is self-determination and full actualization even in matters of health. People should able to take control of their health. Empowerment as a constitutive element in a human rights-based accountability for health can be based on Sen's model of substantive freedoms, which are both the primary end and the means of development.[89] He looked at substantive freedoms as involving a process in which

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the 1993 Vienna Declaration and Programme of Action have clear provisions on participation.

85. *See*, Hunt et al, *supra* note 78.

86. *Id.*

87. *Id.*

88. *See*, The Right to Participation, available at <http://www.frontlinedefenders.org/node/701> (last accessed 18 August 2009).

89. *See*, AMARTYA SEN, DEVELOPMENT AS FREEDOM (1999).

freedom of action and decisions must be allowed; and where people have opportunities and capabilities, for instance, to escape premature mortality, preventable morbidity or involuntary starvation,[90] all of which need empowerment if people are to achieve substantive freedoms to live a life they have reason to value.[91]

J. Monitoring and Accountability

According to Yamin, accountability is a central feature of any rights-based approach to health because it converts passive beneficiaries into claims–holders and identifies states and other actors as duty-bearers that can be held responsible for their discharge of legal, and not merely, moral obligations.[92] She argues that while national authorities have the primary obligation to realize the right to health, 'donor states and other actors have parallel obligations'[93] and should be held accountable. She further maintains that both '[g]overnments and donor states alike should be held accountable for ensuring structural and institutional measures to prevent *de facto* discrimination in health programmes, including the use of disaggregated indicators that provide incentives to consider distributional effects and not merely aggregate advances.'[94]

Hunt et al have highlighted that 'accountability mechanisms provide rights-holders (individuals and groups) with an opportunity to understand how duty-bearers have discharged their obligations, and it also provides duty-bearers (e.g ministers and officials) with an opportunity to explain their conduct.'[95] Thus, monitoring and accountability encourage the effective use of resources, since they help to 'ensure that health policies, programmes and practices are meaningful to those living in poverty.'[96]

In summary, any effort aimed at the promotion of the right to health must be respectful of the above ten elements of the right to health analytical framework. Hunt et al caution that 'states are required to conform to the key features as a matter of binding law. Moreover, they are to be held to account for the discharge for their right-to-health responsibilities arising from these legal obligations.'[97]

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90. *Id.*
91. *Id*., at 18.
92. *See,* A.E. Yamin, *Beyond Compassion: The Central Role of Accountability in Applying a Human Rights Framework to Health, in* 10 HEALTH & HUM. RTS J. (2008), at.1.
93. *Id*.
94. *Id*., at 13.
95. Hunt et al, *supra* note 78, at 347.
96. *Id*., at 338.
97. *Id.*

IV. APPLYING A HUMAN RIGHTS-BASED ACCOUNTABILITY FOR HEALTH IN UGANDA

A human rights accountability to promote 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, which the States sign and ratify, and on international conventions and various mechanisms that operate in the UN and at the national level.[98]

At the macro level, a human rights accountability for health prescribes that Uganda provides adequate funding for health; that Uganda 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; that Uganda tackles environmental issues such as air pollution (due to dust, noise, industrial toxic gas); Uganda takes seriously the issue of neglected diseases; that Uganda fights maternal and infant mortality; that Uganda 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 that Uganda 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 accountability for 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 at micro level delays in receiving care at the healthcare facility. It tackles rights-based problems, including the dismissive attitude of healthcare providers, the high market prices for hospital equipment; healthcare insurance and traditional health care providers.

The human rights-based accountability for health calls for all stakeholders in the promotion of the right to health to consider in the highest esteem, both the process and human interactions that are so crucial to the full realization of this right. Thus,

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98. *See*, L.P. Freedman, *Using Human Rights in Maternal Mortality Programs: From Analysis to Strategy, in* 75 INT'L J. GYN. & OBST. (2001), at 51 & 53.

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.[99] At both the macro and micro levels, human rights principles guide the analysis, design, implementation, monitoring and evaluation of health-related programmes.

V. THE RIGHT TO HEALTH IN UGANDA

The right to health in Uganda is provided for under the Uganda Poverty Reduction Strategic Plan (PRSP) that 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. On the one hand, Uganda has registered tremendous progress in the design and implementation of programmes, which 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. There was also an increase in the number of health facilities. The abolition of user fees in 2001 also led to an increase in health service utilization, especially the out patient department (OPD) attendance from 41% in 1999 to 84% in 2002.

The Uganda Government has also made remarkable progress in its campaigns to control malaria, TB, and measles. Despite improvements, problems remain. Thus, infant, child and maternal mortality rates are still high. A case study done by the Uganda Debt Network in 2003 revealed that infant mortality among the poor is 80% higher than among the non-poor,[100] and it remains high now. The quality of healthcare service-delivery is still poor due to lack of qualified staff and there is a shortage of drugs, especially in rural remote areas. The poor are not able to access health facilities. Poor women are less able to access care for the problems associated with childbirth. Generally, the poor outlying rural districts have shown little improvement in basic social and economic conditions. In many areas, particularly the north that was ravaged by conflict, the essential facilities that support livelihoods have still not been restored.[101] Investment in social sectors such as education and health, have failed to improve the

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99. *Id.*, at 55.

100. *See*, Uganda Debt Network, The Poverty Reduction Strategy Papers (PRSP) and Resource Allocation to the Health Sector in Uganda (Discussion Paper No. 7, April 2004), available online at <www.eldis.org/static/Doc16789.htm>

101. *See*, Report of the Special Rapporteur, *supra* note 51, ¶ 51.

overall level of service delivery.[102]

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, the strategy does not qualify to be pro-poor, as it does not properly follow a human rights-based approach. 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.'[103]

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 accessing healthcare services. It must also articulate the issues of non-communicable diseases and the concerns of disabled persons among the poor communities. The PEAP does not consider health as a fundamental human right. No wonder, therefore, there are no measurable indicators to monitor short-term progress in the implementation of the right to health. A critical evaluation of the PRSP health sector reveals a limited discussion of financial barriers to care, the impoverishing impact of catastrophic illnesses like HIV/AIDS, or accidents. It also reveals the 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,[104] together with a failure to address the problem of neglected diseases.

A human rights-based accountability for health obliges the primary healthcare policy 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 Plan has not achieved one of its primary objectives, that is, achieving 80% of the entire

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102. *See*, KREIMER ET AL, UGANDA POST-CONFLICT RECONSTRUCTION: COUNTRY CASE STUDY (2000).

103. *See*, Uganda Debt Network, *supra* note 100.

104. *Id.*, at 9.

population having access to health facilities by 2005 was not achieved. 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.[105]

Generally, the health services are still poor especially in remote areas due to understaffing, poor terms and conditions of work, and low salaries which are sometimes delayed. While the trained staff concentrate in urban centres, they lack supervision and because of this, their quality of service is below the average standard.[106] To reduce discriminatory tendencies in the health sector, there is a need to make reproductive health services accessible by all people in rural areas. The ministry of Health should provide for an efficient emergency maternal referral system at the health sub-district level. It should also facilitate village health units 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[107] at these hard-to-reach health units. It must also increase efforts to sensitize communities on the value of the delivery care.

Although it is true that the HSSP in the Uganda PRSP faces a number of challenges (mainly, a gap in funding due to the expenditure ceiling imposed on by MFET and inadequate human resources),[108] there is a need for intensive health promotion, education and coordination by all stakeholders. In a country like Uganda where health insurance companies are just coming onto the market, there is 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 maximizing profits. Charles Bwogi reported that many insurance companies had been excluding coverage for people living with HIV/AIDS despite the fact 'insurance policies are meant to offer social-health protection to all groups of people.'[109] A number of healthcare insurances have appeared in Uganda, including Microcare; OracleMed, a South African-based company; and Health Maintenance

105. *Id.*

106. *See*, UPPAP II.

107. *Id.* The UPPAP II report highlighted lack of adequate qualified staff generally, mainly doctors, anaesthetic staff and laboratory technicians.

108. *Id.*, at 11.

109. *See*, C. Bwogi, *HealthCare Insurance Schemes Taking Shape*, THE NEW VISION, September 28, 2005 (citing Dipankar Mahaalanobis, Managing Director of Microcare).

Organizations (HMOs) like IAA and AAR who offer health insurance products.[110] The current Insurance Act,[111] which created the Uganda Insurance Commission that regulates health insurances, does not have provisions for regulation of the Health Maintenance Organizations (HMOs).

Unlike the 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.[112] Uganda should revise its insurance legislation to include provisions that govern the operation of HMOs, 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) was to start operating in July 2007. However, as it was to target employees of the formal and informal sectors first, the poor and most vulnerable 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.'[113] So could it possibly be maintained that this health insurance scheme is discriminative? 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.

A. The Uganda Ministry of Health and the Right to Health

The Uganda Ministry of Health has its mission as 'to provide a network of functional, efficient and sustainable health infrastructure for effective health care service delivery to all the people of Uganda, thus bringing about the full realization of the right to health. However, there are serious concerns as to whether this mission is being realized. Among the various reasons is the fact that the Ministry of Health has not fully considered a human rights-based accountability for healthcare in Uganda. This

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110. 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.

111. Cap. 213.

112. *See*, Bwogi, *supra* note 109.

113. 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.

accounts for the continued existence of discrimination and stigma among the poor members of society, most especially those suffering from neglected diseases. The poor and the most vulnerable are far from realizing their right to health since not many are yet able to access adequate medical care. The construction of new health centres, and the rehabilitation and upgrading of existing health facilities has not yet been accomplished to satisfy the demand.

The very poor state of the roads up-country worsens accessibility to health units especially when it rains heavily. There are very limited ambulance services, if any at all, to transport the 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, as has already been seen above. 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 World Bank, controls the aid that goes to the health sector. It urges that since Uganda depends much 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.[114]

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 as regards 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. Sachs has argued—and I concur—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 can fully absorb [any] massive increases in foreign grants for health than [what the] donors are likely to make available.[115]

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114. For a detailed explanation of the 'Dutch Disease,' see C.S. Adam & D.L. Bevan, Aid, Public Expenditure and the Dutch Disease, 2003, available online at <http://econwpa.wustl.edu/eps/dev/papers/0409/040927.pdf> (accessed December 18, 2005).

115. J.D. Sachs, *Open Letter to the Government of Uganda*, THE NEW VISION, 23 May 2002.

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.'[116] The Uganda Debt Network once reported that there were instances where the donors' funds were rejected by the MFPED, citing macroeconomic concerns.[117] 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.'[118] The Uganda Government should address the shortage of funds to the health sector by increasing domestic resource mobilization 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 shs. 7 trillion). This is a good practice which should be emulated by other donors. It is assumed that a portion of that money will go a long way in uplifting the standard of health care services in Uganda.

B. Monitoring and Evaluation

The HSSP in the Uganda PRSP used mortality rates and identified process indicators: the DPT3 immunization 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 the Government of Uganda makes all efforts to find out whether or not the health strategy benefits the poor and the most vulnerable. The monitoring indicators used to measure progress do not measure the impact of the strategy on the poor people or regions. For instance, the indicators used (e.g. the per capital level and age-specific outpatient department utilization; the percentage of children under one year with DPT3 immunization according to schedule; and the proportion of health centres with minimum staffing norms) do not actually reveal whether the poor and the most vulnerable members of society are benefiting or not from the health strategy.

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 to all stakeholders periodically. Such a report would provide the basis for

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116. *See*, Omaswa, *quoted in* W. Nyamugasira & R. Rowden, New Strategies, Old Loan Conditions, 2002, available at <http://www.brettonwoodsproject.org/topic/adjustment/ Ugandaanalaysis.pdf> (accessed December 18, 2005).

117. *See*, Uganda Debt Network, *supra* note 100, at 8.

118. *See*, D.E. Bloom, D. Canning, and J. Sevilla, The Effect of Health on Economic Growth: Theory and Evidence (National Bureau of Economic Research Working Paper No. 8587, 2001).

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 realization 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 Uganda Government and the international community.

C. Accountability Mechanism

In a human rights-based accountability, rights imply duties and duty demands accountability. This approach identifies duty bearers (the State) who are responsible for ensuring that the right to health is realized. The approach also identifies the poor and the most vulnerable as the rights claimants who hold the States accountable for any failure in their duties. Accountability procedures extend to the recipient governments as well as to the donor community, intergovernmental organizations, international NGOs and to transnational corporations whose actions can violate or promote the right to health of the poor.[119]

There are a number of proper and effective mechanisms to hold the duty bearers (including donors), accountable for failure to secure programmes that contribute to the progressive realization of the right to health. The Paris Declaration on Aid Effectiveness provides a good example that should be emulated in this regard. At the international level, it established mechanism whereby donors and recipient governments are held mutually accountable to each other.[120] At the national level, the Paris Declaration encourages partners and donors to take a joint mutual assessment of the progress made in the implementation of the agreed commitments on aid effectiveness using local mechanisms such as consultative groups.[121]

In Uganda, there are both judicial and quasi-judicial means that the poor could use to pressurize the duty bearers to bring about progressive realization of the right to

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119. *See,* Paris Declaration on Aid Effectiveness: Ownership, Harmonization, Alignment, Results and Mutual Accountability (2005). This Declaration created strong mechanisms for mutual accountability.

120. *Id.*, ¶ 9.

121. *Id.*, ¶ 50.

health. The judicial means include the national courts of law,[122] while the quasi-judicial include the Uganda Human Rights Commission, human rights organisations (like Human Rights Network (HURINET), the Uganda Women Lawyers Association (FIDA-U)) 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 little progress made over the years in bringing about the full realization of the right to health. Documented court cases are not available 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, implying that there are no such incidences. 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.[123] 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.

Furthermore, there is an urgent need to educate people about their human rights in general and the right to health in particular. They should be made aware of the available complaint mechanisms to resort to in case their human rights are violated, including the right to health. Health education needs to be properly streamlined, and there is need to provide information on prevailing health problems and measures taken to prevent and control them.[124] It should also have health activities for parents to help them ensure the proper development of their children. It should also have health education for young people aimed at exposing the dangers of alcohol and drug abuse as well as eating disorders.[125] Moreover, health education is found to be one of the most

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122. 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 competent court for redress, which may include compensation; and article 50(2) provides that any person or organization may bring an action against the violation of another person's or group's human rights. Article 50(3) provides that any person aggrieved by any decision of the court may appeal to the appropriate court, while clause (4) of the same article requires Parliament to make laws for the enforcement of the rights and freedoms under this Chapter (Chapter 4).

123. *See*, POTTS, *supra* note 6, at 5.

124. *See*, Guidelines, UN Doc. E/1991/23/ SUPPL. No. 3, at 105; UN Doc. E/C. 12/ 1994/W, QUESTION 25, at 14.

125. *See*, Second Report of the Federal Republic of Germany, UN Doc. E/1986/A/ASS.10, ¶ 124.

effective tools in the fight against HIV/AIDS.[126] The curriculum for training health professionals should contain human rights education, including education on the right to health of both the health professionals themselves and those of the 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 realization of the right to health in Uganda.

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 in front of their children. Young people were normally left alone to discover by themselves all about this important aspect of human life. 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 of which have adverse implications for the right to health. The most affected by this lack of sex education are girls and women who become vulnerable to violation from men.

D. Participation

Active participation is one of the major principles in a human rights accountability to promote the right to health. 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 realization of the right to health considers the importance of achieving health-related objectives and the process by which such objectives are achieved.[127] In the Uganda HSSP, the poor do not actively participate in the design, implementation or monitoring of the process aimed at bringing about the realization of the 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.'[128] In this regard, the health component of the Uganda PRSP is discriminatory as far as the right to health of the poor is concerned. Thus, there exists a serious violation of the right to health of the poor.

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126. Representative of Netherlands, UN Doc. E/C. 12/1989/SR.15 ¶ 59. The importance of health education for the people was emphasized a long time ago in history. Sigerist maintains that the French philosophers, for example, recommended health education for the people. *See*, H.E. SIGERIST, MEDICINE AND HUMAN WELFARE 80 (1941); G. ROSEN, A HISTORY OF PUBLIC HEALTH 109 (1993).

127. *See*, REPORT OF THE UN SPECIAL RAPPORTEUR ON THE RIGHT TO HEALTH, UN DOC A/60/348, submitted in accordance with Commission Resolution 2005/24, at 12.

128. *See*, Uganda Debt Network, *supra* note 100, at 8.

VI. CIVIL SOCIETY AND A HUMAN RIGHTS ACCOUNTABILITY FOR HEALTH IN UGANDA

Civil Society Organizations (CSOs) make a great contribution in any development work. They are very innovative in service delivery, building local capacity, and can efficiently and effectively advocate for the poor. However, to be able to play this constructive role in society, CSOs need to work hand in hand with the Government. However, 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. In Peru, for instance, Local Health Administration Committees (*Comites Locales de Administracion de salud, CLAS*) participate fully in government health programmes and contribute meaningfully to the progressive realization of the right to health.

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 true 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 realize 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.[129] 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.[130]

VII. MULTINATIONAL FINANCIAL INSTITUTIONS AND A HUMAN RIGHTS ACCOUNTABILITY FOR 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 realization 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;

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129. *See*, J. COURT ET AL, POLICY ENGAGEMENT: HOW CAN CIVIL SOCIETY ORGANIZATIONS BE MORE EFFECTIVE? (2006), at 1, available at <www.odi.org.uk/Rapid> (accessed 4th July 2006).

130. *Id.*

yet the World Bank is aware of the interconnectedness between the rights to health, education, and freedom from non-discrimination. According to a 2005 World Bank study:

> 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 immunized. Supporting these conclusions are careful analyses of household survey data that account for other factors that might improve care practices and related health outcomes.[131]

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. By supporting the Uganda PRSP that does not treat health as a human right, the World Bank and IMF also violate the right to health in Uganda. They ought to constructively criticize 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 proved in Uganda. Nevertheless, they agree that these financial institutions support this policy (of budget ceiling).[132] There is great need for these institutions to look beyond macroeconomic stability. The IMF should allow increase in concessional aid, in the form of grants that can have little impact on the macroeconomics of the country. Although, already, the IMF is supporting the call for donors to meet the 0.7% of their gross domestic product and provision of aid over a long-term, it should provide analyzes of how much additional aid could be absorbed by a low-income country such as Uganda, before upsetting a macro-economy of such a country. Otherwise, increased funding to the health sector should be a priority, if the

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131. *See*, WORLD BANK, ENGENDERING DEVELOPMENT THROUGH GENDER EQUALITY IN RIGHTS, RESOURCES AND VOICE (2005).

132. *See*, J. Odaga & P. Lochoro, *Budget Ceilings and Health in Uganda*, CARITAS UGANDA, January 2006, at iii.

right to health is to be promoted in Uganda.[133] The international trade practices of pharmaceutical companies may have an adverse effect on the realization 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.

VIII. 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.'[134] 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 public about the dangers of using drugs. Toebes argues that the US authorities violated an obligation to fulfil the right to health.[135] The authorities 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 mortality but only imprisoned drug users which, *inter alia,* led to increased cases of HIV/AIDS in the prisons.[136]

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.[137] Uganda may implement this obligation 'progressively' and to the maximum of its resources.[138] 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. From a human rights perspective, and according to WHO, the basic essentials of the right to health entail a number of elements. The first is primary healthcare, which includes at least education concerning health problems and the methods of preventing and controlling them. The second is the promotion of food supply and proper nutrition.

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

134. *See*, TOEBES, *supra* note 56, at 328.

135. *See also*, B.X. Waltkins et al, *Arms Against Illness: Crack Cocaine and Drug Policy in the United States*, 2 HEALTH & HUM. RTS (1998), at 48-58.

136. *See*, TOEBES, *supra* note 56.

137. *Id.*, at 332.

138. *See*, Article 2(1) ICESCR.

The third one is the adequate supply of safe water and basic sanitation and, the fourth covers maternal and child health care, which includes family planning; immunisation against the major infectious diseases. Lastly, it includes the appropriate treatment of common diseases and injuries and the provision of essential drugs.[139]

In providing these healthcare services to people, the principle of non-discrimination must be upheld.[140] 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;[141] and the equipment and drugs must be adequate for all the people in Uganda.[142] Surprisingly, although discrimination may not be expressly rooted in the laws of Uganda, it is exercised in access to healthcare and to the underlying determinants of health (safe drinking water, housing, nutritious food, and a healthy environment).[143] 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 of CEDAW) all constitute a violation of the right to health of the people.

Uganda must take action to improve the health situation of prisoners. The prisons are very congested, and have poor sanitation. Sometimes prisoners sleep on the floor without blankets. They have no opportunity for physical exercise and recreation, and often have poor nutrition. However, it may actually be hard to improve the prisoners' health condition when that of the prison warders and other law enforcement agents like the police also leaves much to be desired. Crucially, any effort to improve the health situation should therefore be comprehensive enough to cater for all the

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139. *See*, World Health Organization, Declaration of Alma Ata on 'Health for All and Primary Healthcare strategies' (International Conference on Primary Healthcare, Alma Ata, September 6-12, 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* THE MAASTRICHT GUIDELINES ON VIOLATIONS OF ECONOMIC, SOCIAL AND CULTURAL RIGHTS (T.C. van Boven et al eds., 1998), at 60. The same message is quoted by TOEBES, *supra* note 56, at 288.

140. *See*, ICESCR, arts 2 & 3; CEDAW, arts 1 & 2.

141. *See*, UN Doc. E/1991/23, Suppl. No. 3, indicators 4(f)-(h) on proportions of population/pregnant women/infants having access to trained personnel for care.

142. *See*, UN Doc. E/C.12/1995/SR.14, ¶ 55; UN Doc. E/1986/4/Add. 9, at 9; UN Doc.E/1990/5/Add. 13, ¶ 107.

143. A similar form of discrimination happened in Serbia. *See*, FIDH, SERBIA: DISCRIMINATION AND CORRUPTION—THE FLAWS IN THE HEALTHCARE SYSTEM (International Fact-finding Mission Report to the Committee on Economic, Social and Cultural Rights in Application of the International Covenant on Economic, Social and Cultural Rights, May 2005), at 15.

people including prison warders and other law enforcement agents. Measures to promote a healthy environment include those that conserve natural reserves, prevent deforestation and clean up chemical dumps.[144] 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. However, most important of all for the Government is a serious political commitment to promote the right to health; such a commitment is manifested through national policies and legislation aimed at fostering the achievement of the progressive realisation of the right.[145]

The good thing is that there is already Government will in Uganda to promote the right to health of the people. In a speech at the 4th Conference of African National Human Rights Institutions held in Kampala in 2002, the President of Uganda showed that he was fully aware of the fact that in Uganda, just like in other African countries, the realization of the right to health is still elusive.[146] He was convinced about the central role that issues of health play in any meaningful development strategy. He now and again reiterated his commitment to truly advance human rights and development through the promotion of good governance and the rule of law. He supported the advancement of basic economic, social and cultural rights, namely, the right to education, and showed interest in the promotion of the right to health and other determinants of health, such as clean water, adequate food and safe sanitation. He showed that he values the efficient use of available resources through proper planning and implementation, and the elimination of corruption by democratically empowering all the people to participate fully and actively in matters regarding their health and development aid generally.[147]

In a way, the President of Uganda appreciates the central importance of the State in building an environment that supports the adoption of a rights-based approach to the right to health in particular, and to development in general. However, efforts to implement Uganda's commitments and obligations in relation to the right to health through national poverty-reduction strategies, national health policy and national health sector strategic plans have not been very successful as seen above.

However, in its commitment the Government must set up a timeframe in which to realize the right and also set up health-related indicators and measurable targets that

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144. *See*, Second Report of Canada, UN Doc. E/1990/6/ADD.3, ¶ 23.

145. *See*, CEDAW, art. 2 (obliging States parties to take legislative measures to promote and protect the right to health). Article 3, on the other hand, recommends measures other than legislative ones.

146. *See*, Speech by His Excellence, Yoweri Museveni, at the Opening of the 4th Conference of African National Human Rights Institutions, Kampala, August 14, 2002, at 8 (available online at <www.nhr.net/pdf/African4thNhri>).

147. *Id.*

help in the evaluation of whether the progressive realization of the right to health is being achieved or not.[148] 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.[149] Nonetheless, since the right to health requires the development of an effective and inclusive health system of good quality, 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.[150]

In a similar vein, in a transparent and participatory manner, 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 (PEAP). Particularly, the Ministry of Finance, Planning and Economic Development should increase budgetary allocations to the Ministry of Health, to effectively, improve on the terms and conditions of health workers, especially of those working in rural and remote areas. This motivation strategy could include provision of better accommodation with good facilities like electricity and water for healthcare workers; and, increased salaries and the timely payment of healthcare workers, as recommended by the Uganda Human Rights Commission research on health rights.[151]

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148. *See*, YOUR RIGHTS (J.M. Waliggo et al eds., 2005), at 5, available at <www.uhrc.org>

149. *See*, B. ANDERSASSEN & H.O. SANO, WHAT'S THE GOAL? WHAT IS THE PURPOSE? OBSERVATIONS ON HUMAN RIGHTS IMPACT ASSESSMENT 15 (2004).

150. 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, healthcare workers and civil society.' *See*, UN Doc. A/60/348, at 17.

151. YOUR RIGHTS, *supra* note 148, at xvii. The research recommended the following to the Ministry of Health: increased salaries to health workers in order to check on rampant corruption; constant and timely supply of drugs in all health facilities; provision of cost-effective running water (spring protection, harvesting rainwater and boreholes); provision of a balanced diet for patients to enhance their body immunities; provision of electricity and laboratory services to rural health units; the construction and expansion of some health units in order to solve the problem of congestion; securing ambulance services to transport referral cases; employment of more trained staff to all health facilities (and the staff should have chances for refresher courses); and giving priority to the needs of vulnerable groups, like PLHA, PWDs, children, and poor pregnant women. However, I think that a human rights based accountability

Uganda must devise a health system that focuses on the disadvantaged, the most vulnerable in society and those living in poverty. Until recently, the people of northern Uganda have been living very desperate health conditions. The health condition of the internally displaced persons (IDPs) in Gulu, Kitugm and Pader is appalling. The northern conflict between the Uganda People's Defence Forces (UPDF) and the Lord's Resistance Army (LRA) led by Kony forced people into camps with no adequate shelter, no adequate safe water, no quality sanitary provisions and no access to timely healthcare services. There is a 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.

In short, the use of a human rights-based accountability to promote health is not an option. Uganda must pay attention to its obligations in relation to the minimum core content of the right to health, which include the recognition of and commitment to a right to health for all citizens and residents. It has to adopt a national health policy based on the ten key right to health analytical framework mentioned above, if the full realization of the core minimum of the right to health is to be achieved. The Ministry of Health must improve its ability to monitor health policies and evaluate health outcomes so as to be able to judge whether the progressive realization of the right to health is on course or not.

Uganda urgently needs an essential public health infrastructure that will protect and promote the health of the people equally, through the provision of adequate, safe and clean water and sanitation for all. Crucially, the Ministry of Health must adopt measures to control and prevent the transmission of major epidemic and endemic diseases such as ebola, diphtheria, tetanus, poliomyelitis, tuberculosis, whooping cough, and measles. The fight against HIV/AIDS is not yet over. Uganda must do more to prevent the scourge. To this end, it is essential to invest in health and reallocate resources in a cost-effective way, and make reproductive and family planning information and services readily available to all persons. At the same time, Uganda needs international assistance and co-operation in a spirit of shared responsibility. Thus, all Uganda's development partners need to ensure that both international trade agreements and humanitarian assistance promote the right to health other than having adverse effects on it and on all other human rights.

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for health better summarizes these recommendations.