

Review of constitutional provisions on the right to health in Uganda

A case study report



CEHURD
social justice in health

**Centre for Human Rights and
Development (CEHURD)**

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Executive summary

This case study is produced by the Centre for Human Rights and Development (CEHURD) in the theme work on health rights and law of the Regional Network for Equity in Health in East and Southern Africa (EQUINET). It examines how the right to health is enforced in Uganda, how it was implemented, and how health rights advocates have suggested the provision be constitutionally interpreted. It is a follow up on the results of work on the right to health that highlighted a need to do further studies in countries that do not have expressed provision on the rights to health.

The right to health is one of the fundamental rights for all human beings and several international and regional legislative instruments have been put in place to ensure the realization of this right globally and regionally. Following this guidance, the national level constitution mandates the state to promote, respect and fulfil this right by making provisions to observe health. Considering its supremacy, writing the text in the constitution is just as important as translating it into action. On its own, the constitution is not a practical guide for daily operations because it is full of general and abstract principles. Constitutional implementation is a process designed to ensure the full, effective and continuous application of a constitution by promoting, enforcing and safeguarding it. Failure to implement the provisions therein leaves its goal unattained, and if implementation is left to State leaders or officials, the objectives will not be met.

While there is evidence of health benefit in countries where the right to health is explicitly enshrined in the substantive parts of the constitution, there is a paucity of knowledge on implementing implicit constitutional provisions on the right to health in Uganda. This case study identifies the pros and cons of realising an implicit right through political, judicial and popular mechanisms. The objectives are threefold: a) to review the international, regional and national law on the right to health; b) to analyse the role of the political, judicial and popular mechanisms of constitutional implementation in the realisation of the right to health in Uganda; and c) to identify the challenges in the implementation of constitutional provisions on the right to health.

The methodology included a content review of legal documents both at international and national level. To answer the broader question on how the right to health is being implemented in Uganda, a validation meeting for a first draft was held with different stakeholders to discuss the three forms of implementation of constitutional provisions in Uganda, and related sources of information. The latter included paper-based and electronic online sources of scholarly literature, media sources, conference papers and case reports. We noted from this consultation that CEHURD, the author, is a primary litigant on the right to health in many of the cases highlighted and bring their own direct experience.

The Ugandan government has ratified a significant number of international and regional instruments which recognize and guarantee the right to health. They elaborate its prerequisites, components and the standard to which it should be enjoyed. They further impose obligations on various stakeholders such as the state, individuals, civil society and international community to promote and implement the right. Furthermore, they reinforce the right to health by providing for other supportive rights and freedoms such as life, equality, dignity and access to information, thereby creating an increasingly enabling environment for implementation.

In Uganda, the text on human rights was generally first adopted in the 1995 constitution which is currently in force. The constitution has explicit provisions on enforcing rights such as the rights to life, privacy, freedom from torture, and education, among others, but not explicitly the right to health. The right to health was included in several provisions under the national objectives and directive principles of state policy that can be used to protect the right to health. Uganda has also enacted numerous statutory laws to enforce the right to health.

Having documented legal provisions is not enough to realize the right to health. The political will to create and enforce policies that support the realization of the right to health is a factor in the constitution's implementation.

The report presents a number of policy documents that have been put in place to reflect international commitments, including in line with the United Nations Sustainable Development Goals. They are guided by Uganda Vision 2040, which provides direction to all governmental initiatives that aim to fulfil duties and responsibilities, including in for providing health care. The vision also commits the government to ensure that Human Rights Based Approach is applied in policies, laws, and programs to strengthen government officials' capacity to respect and protect human rights.

Specific to health, government has laid out policies and plans to ensure universal health coverage. There is a documented policy shift from facility based health service delivery to household based service delivery, although the framework for this is not yet in place. Mechanisms to ensure transparency and accountability system in health care system are also still unclear in policy documents. Collaboration between different ministries, departments and agencies, important for realization of the right to health, is still not reflected in a multisectoral strategy to support it. Political implementation of the right to health through the decentralized structure is challenged by weak health systems.

Another form of implementation of constitutional provisions is through the judiciary. Article 129 of the Ugandan Constitution establishes the hierarchy of Ugandan courts through which legal redress can be sought in the event of violation of the right to health. While there is increasing litigation on the right to health, documented in the report, it is still scanty. This could be explained by a lack of understanding of human rights doctrine by judicial officers or their caution on litigating on social transformation.

There has been a rise in popular implementation of constitutional provisions, with cases described in the case study. This form of implementation has created national discussions on government spending and also empowered individuals and groups to make government accountable on their delivery of health services. Popular activism has also leveraged social media in the mobilisation of citizens by quickly garnering people from different regions behind a cause or event. Unfortunately, this has sometimes met resistance, violence and threat, and it has been sporadic and unsustainable.

The case study thus raises a number of challenges in implementing the constitutional provisions on the right to health. These range from constitutional; legislative and policy and institutional barriers. It also points to the economic and service; cultural and religious barriers that need to be addressed to implement the right to health; and the strengthening of as social mobilisation and accountability mechanisms.

While the right to health is yet to be explicitly incorporated in the Ugandan constitution, the case study points to a number of ways to implement it. Several issues merit future attention to support this, including: developing increased measures and capacities for accountability; integrating a rights based approach in a multi-sectoral response; ensuring adequate resources to the health system; strengthening judicial understanding and implementation of health rights; and strengthening issue based civil society groups and processes that are focused on advancing the right to health with the intention to realize positive public and policy outcomes.

1. Introduction

This case study is produced by the Centre for Human Rights and Development (CEHURD) in the theme work on health rights and law of the Regional Network for Equity in Health in East and Southern Africa (EQUINET). It examines how the right to health is enforced in Uganda, how it was implemented, and how health rights advocates have suggested the provision be constitutionally interpreted. It is a follow up on the results of work on the right to health that highlighted a need to do further studies in countries that do not have expressed provision on the rights to health.

The right to health is a fundamental human right which forms the foundation of human existence. Human rights work is fuelled by a dedication to the protection of the rights essential to the respect of all individuals and requires an understanding of socioeconomic factors and the interconnectivity of human rights. For example, the right to the highest attainable standard of health is closely related to other human rights, such as the right to food, housing, and education. The World Health Organisation (WHO) defines health as the state of complete physical and mental wellbeing and not merely the absence of infirmity or disease (WHO 1946). Thus, the right to health extends itself to the causal determinants of health such as adequate sanitation facilities, health infrastructure, trained workers and essential drugs. In essence, health is both an inalienable prerequisite for, as well as an indispensable outcome of, the enjoyment of all other human rights.

Several international, regional and local legislative instruments provide for the right to health, whether explicitly or by implication. Unfortunately over half of the countries worldwide do not have the right to health enshrined in their national constitutions (Heymann et al, 2013). However, the ones who have recognized it both globally and Africa-wide require that it is enjoyed to the highest attainable standard as found in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) and Article 16 of the African Charter on Human and Peoples Rights (ACHPR) (UN, 2008; OAU, 1982). Taket (2012) suggests that this obliges states to put in place policies and plans which avail the population with access to health services in the shortest delays possible. This creates a positive standard free from any written constraints. In reality however, it is rather ambiguous, ever-changing and risks being elusive to implement.

In an effort to resolve the ambiguity, some instruments have elaborated the precise components of the right to health, such as in ICESCR Article 12; Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) Articles 12 and 14 ; Convention on the Rights of Persons with Disabilities (CRPD) Article 25; ACHPR Article 16; Women's Protocol to the ACHPR Article 14 (UN, 1979; 2007; 2008; OAU 1982). For instance, Article 14 of the ACHPR unambiguously provides for health and reproductive rights and empowers women to control their fertility, decide whether to have children, their number and spacing. It further obliges state parties to take appropriate measures to establish and strengthen existing pre-natal, ante-natal, post-natal and nutrition services for women and their children.

Closer to home, Article 118 of the Treaty for the Establishment of the East African Community (EAC) obliges the partner states to promote harmonised national health policies and regulations, enhance the efficiency of health care systems and cooperate in the development of reproductive health services (EAC, 1999). Although Uganda is a signatory to many of those instruments and recognises the right to health in national legislation, its constitution lacks an express provision for it. Instead, the right is merely inferred from several other guarantees under the national objectives of state policy, including: Article 21 on equality, Article 22 on life, Article 31 on family rights, Article 32 on affirmative action, Article 33 on women's rights, Article 39 on the right to clean and healthy environment, and Article 41 on information access, among others (Republic of Uganda, 1995a).

Both qualitative and quantitative studies show the benefits of nations enshrining the right to health in their constitutions (Kavanagh, 2016). As the supreme law of the land, when a

constitution guarantees the right to health, it endorses its legitimacy and sets its implementation as a priority. Constitutional clauses on the right to health also serve as points of reference and advocacy tools. However, on its own, the constitution is not a practical guide for daily operations since it contains general and abstract principles. This gap therefore warrants framing of legal steps to operationalize it and enable the text to infiltrate the perceived reality of people (Fombad, 2016).

1.1. Constitutional provisions on the right to health in the region

In 2010, CEHURD, under the Regional Network for Equity in Health in East and Southern Africa (EQUINET) conducted a desk review of the constitutional provisions on the right to health in fourteen countries in the region (Mulumba et al., 2010). The study found that health is incorporated in various international and regional human rights treaties as well as national constitutions, laws and policies. They also established that many constitutions are silent about the right to health, which necessitates its inference from other complementary rights that are explicitly stipulated such as life, equality, safe working conditions and freedom from torture.

Accordingly, the study assessed the sufficiency of the constitutional framework on health rights in line with General Comment No.14 of the constitution which outlines six core obligations of the respective governments to ensure the following for its citizens:

- I. access to health facilities, goods and services without discrimination;
- II. freedom from hunger by access to essential, nutritionally adequate and safe food;
- III. access to basic shelter, housing and sanitation with safe, potable and adequate water;
- IV. provide essential drugs, as defined by the WHO Action Programme
- V. equitable distribution of all health facilities, goods and services; and
- VI. adoption and implementation of a national public health strategy and plan of action.

Most constitutions were found to limit other rights in the interest of public health and safety. Some constitutions restricted the right to health to principles of state policy and objectives, which render it non-justiciable and unenforceable by the courts, while others provide for only isolated elements of the right. Consequently, even if a national constitution is silent on the right to health, countries such as Uganda can still invoke related constitutional rights and provisions of international and regional laws to enforce it.

EQUINET's previous study was limited by three substantive aspects. First, the scope of its subject matter was limited to the black-letter law as stipulated in the constitution, and did not explore the implementation and enforcement of the right to health. Thus, this responsive study extends the scope of the investigation to a situational analysis of the constitutional implementation of the right to health. Secondly, the depth of analysis of Uganda's constitutional provisions on the right to health was constrained by the regional and wide nature of the study. Given the high number of countries studied, specifically 14 countries, it was difficult to perform an in-depth analysis of each constitution. As a result, this study is focused on Uganda and provides an analysis of its constitutional provisions on the right to health. Finally, the initial study was substantively informed by a desk review of the constitutional provisions on health, and it did not concern itself with the implementation of these provisions. This study extends the methodology to cover this gap. We show with this study that although the Constitution is not explicit about the right to health, there are increasing efforts to implement the implicit provisions in the national objectives.

1.2. Implementation of constitutional rights to health

Constitutional implementation is a process designed to ensure the full, effective and continuous application of a constitution by promoting, enforcing and safeguarding it (Fombad, 2016). It is commonly applied through political, judicial or popular implementation, and failure to do so leaves its goal unattained, the populace disillusioned. To that end, Article 58 of the Constitution of Uganda requires the parliament to go beyond its traditional role of creating laws, by formulating policies and running programmes that facilitate the enjoyment of human rights. Further, Article 20(2) of the Constitution obliges all government agencies and persons to respect,

promote and uphold every human right and thus provides a wide human rights implementation scope (Republic of Uganda, 1995a).

Both the executive and the legislative branches implement human rights proactively, while the judiciary generally interacts with them when triggered by litigation by, or on behalf of, an aggrieved citizen. Government efforts are in turn reinforced by individual or corporate citizens and civil society organisations. This study therefore analyses how the different branches of government and the citizens in Uganda implement constitutional provisions on the right to health, with a focus on MCH, even when they do not appear in the substantive provisions.

There are three forms of constitutional implementation that can occur in any country - popular constitutionalism, political constitutionalism and judicial constitutionalism (Gewirtz, 2015).

Popular constitutionalism is interpretation and enforcement of the law by the people. The Ugandan constitution belongs to the people as illustrated in the preamble, "we the people", and it should therefore reflect our desires. In the event that the constitution is abused or threatened, then the people have a mandate to protest and defend. The people are usually represented by individuals and civil society organizations that can interpret the constitution for greater good. These include the media fraternity who can investigate and objectively report violations to increase public awareness, or legal experts who should play watch dog for the rule of law and can step up to defend those with less knowledge as *amicus curiae* (Fombad, 2016; Gewirtz, 2015). Other players can be business persons or activists with vast knowledge of human rights issues.

Political constitutionalism refers to enforcement of the constitution by the executive (the president) and the legislature. This may include opposing of, or refusal to vote for legislation that is interpreted to violate the constitution by law makers. In the event that unconstitutional legislation is passed by law makers, then the president has authority to reverse this decision, with strong evidence of violation of the constitution.

Judicial constitutionalism is the most common form of constitutional implementation worldwide and is based on the premise that the constitution is the supreme law and it is the mandate of the courts to apply the law. No statute therefore can precede the constitution, but rather arguments in the constitution can lead to nullification of a statute or regulation. Furthermore, political constitutionalism may be biased to advance selfish interests, and therefore the judicial process ensures that the political process is controlled.

In this research, these definitions provide our working definition for "constitutional implementation or implementation of constitutional provisions".

1.3. Objectives of and rationale for the case study

This case study aims to conduct a situational analysis of the constitutional implementation of the right to health in Uganda with a particular focus on maternal health. It seeks to investigate whether the current implementation mechanisms suffice to promote, uphold and defend maternal health care in Uganda, even in the absence of an express guarantee of the right to health under the existing constitution.

The specific objectives are;

- a. to review the international, regional and national law on the right to health
- b. to analyse the role of the political, judicial and popular mechanisms of constitutional implementation in the realisation of the right to health in Uganda; and
- c. to identify the challenges in the implementation of constitutional provisions on the right to health.

As noted earlier it builds on previous EQUINET work. By closely analysing the implementation of the provisions relevant to the right to health in Uganda, this case study identifies the pros and

cons of realising an implicit right through political, judicial and popular mechanisms. Hence, it seeks to make a three-pronged contribution as follows:

- a. To add to the existing body of knowledge on the constitutional implementation of rights in the absence of express clauses providing for them. Specifically, it explores, if the right to health is not explicitly in the constitution, how other health related provisions that it contains can be used to implement health rights, the role of the right to health as an integral part and precondition for the enjoyment of all constitutional rights, where rights provided by distinct clauses must complement each other for one to meaningfully exercise the right to health. The findings aim to enable stakeholders in law and policy making, judiciary, healthcare providers, academicians, advocates and the public to appreciate the complementarities of several human rights and their correlation with the right to health.
- b) To provoke a policy debate that assists the Legislators and Law Reform Commission in Uganda to identify gaps in the Constitution and in its implementation mechanisms, and to inform the Commission's amendments towards a more effective promotion and realisation of the right to health.
- c) To inform action from individuals and civil society organisations about the challenges of applying any of the constitutional mechanisms aimed at the implementation of the right to health, to inform future advocacy and reform efforts aimed at its realisation.

These contributions are explored in the subsequent sections of the report.

2. Methods

This case study applied a content review of legal documents both at international and national level. To answer the broader question on how the right to health is being implemented in Uganda, a validation meeting for a first draft was held with different stakeholders including legal experts, members of the academia and representatives from civil society in Uganda to discuss the three forms of implementation of constitutional provisions in Uganda and related sources of information. Through this consultation, we added to the materials reviewed to include paper-based and electronic online sources scholarly literature, media sources, conference papers and case reports. We noted from this consultation that CEHURD, the author, is a primary litigant on the right to health in many of the cases highlighted and bring their own direct experience.

The different forms of implementation as documented were summarised and emerging issues and themes extracted by analysing the content.

The study is restricted in scope, depth and results by two major limitations. The bureaucracy to gain access to certain legal documents and secure interviews with validation experts was time consuming, and impossible in certain circumstances. Future studies may overcome these challenges by using participatory methods involving officials responsible for implementing the law as researchers.

3. International, regional and national laws on the right to health

The Uganda government has ratified a significant number of international instruments which recognize the right to health, such as the Universal Declaration of Human Rights (UDHR), ICESCR, CEDAW, CRPD and Convention on the Rights of the Child (CRC) among others. Uganda is a member state of the WHO, which defines health as the state of complete physical and mental wellbeing, not merely the absence of infirmity or disease (WHO 1946). In the international policy framework before 2015, the Millennium Development Goal (MDG) 5 aimed at reducing maternal mortality. Currently, the Sustainable Development Goals (SDGs) provide a policy regime aimed at transforming the world for sustainable development by 2030, and SDG 3 caters for good health and well-being, and in overcoming inequalities within and between countries globally (UN 2015).

In the absence of an express stipulation of the right to health in Uganda's constitution, this chapter examines key sources of law applicable to the right to health, with a specific focus on international, regional and national laws.

3.1. International law on the right to health

The various international laws relevant to the right to health are shown below, with the year of ratification by Uganda in brackets.

a. The Universal declaration of human rights (UDHR, 1948):

Article 25(1) of the UDHR provides for a standard of living adequate for the health and well-being of all including food, clothing, housing, medical care and security in case of sickness. Article 25(2) of the UDHR supports maternal care by guarantying special care and assistance for mothers including protection for all children, whether born in or out of wedlock. In addition, Article 27(1) of the UDHR states the right to freely participate in the cultural life of the community and to share scientific advancement and its benefits. This promotes the use of both traditional health care and modern medical services. Finally, Article 30 clearly prohibits any State, group or person from interpreting the UDHR to destruct any right. Thus, none of the UDHR clauses can be used to prejudice the right to health in Uganda (UN 1948).

b. International Covenant on Economic, Social and Cultural Rights (ICESCR, 1987)

The ICESCR under Article 12 identifies the right to the highest attainable standard of physical and mental health, and details some actions the State should take to fully realize the right. Details include the reduction of stillbirth and infant mortality rates, the improvement of environmental aspects and industrial hygiene, the prevention, treatment and control of diseases, and the assurance of medical service to all in case of sickness. With Article 2(1) the State agreed to utilise the maximum of its available resources to progressively achieve a full realisation of human rights. This requires Uganda to adopt both qualitative and quantitative mechanisms to give its citizens the most attainable level of health care possible. State performance can be assessed by the AAAQ framework in General Comment 12 on the Right to Health which requires healthcare to be available, and accessible, and of an adequate quality (UN 1982; PWESCR, 2015).

Further, the ICESCR under Article 7(b) provides for safe and healthy working conditions, while Article 10(2) entitles working mothers during a reasonable period before and after child birth to paid leave, adequate social security benefits and special protection. Article 11(1) states recognize the right to an adequate standard of living including adequate food, clothing and housing, and their continuous improvement, including through international cooperation based on free consent as a critical success factor for its realisation. Article 11(2) provides for freedom from hunger, and obliges states, individually and through international co-operation, to specifically improve food production, conservation and distribution by the use of technical and scientific knowledge, the dissemination of nutritional information and agrarian reforms. Article 5(1) prohibits interpretation of the ICESCR to justify anything prejudicial to any right or freedom there under. Better still Article (2) prohibits the restriction of or derogation from any rights on the pretext that the ICESCR does not recognize it fully or does it to a lesser extent.

In terms of accountability, Article 16 of the ICESCR commits the State to submit progress reports to the UN Secretary-General on the measures used to achieve the right to health. By Article 17(2) the reports may show difficulties affecting the degree of duty fulfilment. The Secretary General in turn transmits copies to the Economic and Social Council (ESC) and the specialized agencies for consideration. Article 18 empowers the ESC to arrange with specialized agencies to share decisions and recommendations on implementation. Article 19 also allows the ESC to transmit the reports to the Commission on Human Rights (CHR) for study, general recommendation or appropriate information. By Article 20, the state may submit comments or references to the ESC on any general recommendation in the reports. Further, Articles 21 and 22

allow the ESC to furnish the General Assembly, other UN organs and agencies with recommendations which may assist them to decide on international measures needed for effective progressive implementation. Article 23 elaborates such international actions to include conclusion of conventions, adoption of recommendations, furnishing technical assistance and holding regional consultative meetings with affected governments.

With this wealth of deeply intertwined rights related to health under the ICESCR, and a range of tools and institutions for monitoring its implementation, several opportunities emerge for Ugandans to advance their right to health. For instance, the ICESCR clearly describes the components of the right to health and particularly for maternity, the standard to which it should be enjoyed and the critical success factors for its realisation. Further the ICESCR equips states and the citizens with different mechanisms to implement the law, as well as tools to monitor the progress made and the necessary corrective action in case of setbacks. Lastly, the ICESCR establishes a diversified institutional ecosystem for holding the State accountable in its fulfilment of its duties and enforcing the right to health. The key question arising here is to what extent Ugandans have harnessed these opportunities.

c. The Convention on the elimination of all forms of discrimination against women (CEDAW, 1985)

The CEDAW, Article 4(2) exempts special measures adopted to protect maternity from being discriminatory. Article 5(b) obliges the state to take all appropriate measures to ensure that family education includes a proper understanding of maternity. Article 11(1) entitles employed women to healthy and safe working conditions, protection of their reproductive function and paid maternity leave. Articles 11(2) and (3) cover prevention of discrimination against women on grounds of maternity by obliging states to prohibit unfair dismissal, introduce paid maternity leave or comparable social benefits, guarantee job security and periodically review protective laws in line with scientific or technological knowledge. In the case of *Olga Seniv v Tamem Michael Bridal Limited*, (DEC-EC2010-096) the plaintiff sued for discrimination when the defendant dismissed her upon return from maternity leave, and her replacement continued to carry out her former duties. The Equality Officer held that the defendant had discriminated against her on grounds of gender and ordered compensation of € 20,000 for the effects of the discriminatory dismissal (UN, 1979).

Further, Article 12 of the CEDAW provides for equal access to appropriate health services including family planning, confinement, free services where needed, and adequate nutrition during pregnancy, the post-natal period and lactation. For grass root women, Article 14(2) requires the State to ensure their participation in the elaboration, implementation and benefit from rural planning and development, get access to adequate health care facilities, information, counselling, family planning, and enjoy adequate living conditions such as housing, sanitation, electricity, water transport and communication.

For enforcement and accountability, Article 17(1) of the CEDAW established a Committee on the Elimination of Discrimination against Women to consider the implementation progress. It consists of eighteen to twenty-three experts of high moral standing and competence, elected by their States who must represent the equitable geographical distribution, different forms of civilisation and legal systems. By Article 18(1) the State committed to submit to the UN Secretary-General, for consideration by the Committee, a report on the legislative, judicial, administrative or other measures adopted to operationalize the rights and the progress made every four years and whenever the Committee requests. Such report may indicate factors and difficulties affecting the degree of fulfilment of its obligations.

The effect of the CEDAW is to buttress the rights of women to equal access to appropriate medical services and the highest enjoyment of the right to health. Once again for Uganda, it is vital to establish the effectiveness of the state in its compliance with the CEDAW, its achievements so far and the setbacks. It is also useful to investigate how vigilant the citizens

have been in monitoring state performance and supporting it through private initiatives or synergies, both at home and through international cooperation.

d. The Convention on the Rights of the Child (CRC, 1990)

Since the crux of maternity also includes a child, this study extends to the right to health for children. The preamble of the CRC appeals to the state to bear in mind that by reason of physical and mental immaturity, a child needs special safeguards and care before and after birth. Thus in examining the right to maternal health, this study automatically explores the right to health for a child. Article 3 of the CRC lays down the primordial consideration as observance of the best interests of a child in deciding all matters. Article 6 recognizes the inherent right to life of every child, and obliges states to ensure its survival and development to the maximum extent (UN 1990).

Article 24(1) entitles a child to enjoy the highest attainable standard of health and access facilities for treatment of illness and rehabilitation. By Article 24 (2) the State is obliged to fully implement the right through appropriate measures to diminish infant and child mortality, provide necessary medical assistance by emphasising primary health care development and combat disease, environmental pollution and malnutrition with technology, adequate food, clean drinking water and sanitation. The article incorporates mothers by providing for appropriate pre-natal and post-natal health care, their sensitisation on child health and nutrition, advantages of breastfeeding, hygiene, accident prevention and family planning.

In addition Article 24(3) and (4) impose a duty on the State to effectively abolish traditional practices prejudicial to child health, and to cooperate internationally so as to progressively realize child health, with due consideration of the needs of developing countries. An example of such practices is early marriage. Articles 19 and 34 of the CRC prohibit all forms of child abuse including sexual abuse, and charge the state to take appropriate steps to protect children from sexual inducement, coercion, exploitation and use in pornographic performances and materials. This is particularly relevant for Uganda, where the teenage pregnancy rate among girls aged 15-19 is 25% (UBOS and ICF, 2017), a reflection of early initiation into sex.

Further, Article 25 of the CRC entitles a child duly placed for care, protection or treatment of their physical or mental health, to a periodic review of the treatment and placement circumstances. Articles 27 (1) and (2) entitle every child to a standard of living adequate for their physical, mental, spiritual, moral and social development, and makes the parent(s) or caregiver primarily responsible to secure, within their abilities and finances, the necessary living conditions. In addition, Article 27(3) tasks the State based on its national conditions and means, to assist parents and child caretakers with implementation by providing material assistance and support programmes particularly on nutrition, clothing and housing.

For implementation, Article 42 tasks the State to actively make the CRC principles and provisions widely known. To analyse the progress made, Article 43(1) sets up a Committee on the Rights of the Child, of ten highly moral and competent experts elected from nationals who represent equitable geographical distribution and the principal legal systems. To foster the effective implementation and international cooperation, Article 45 entitles the UN organs and specialized agencies like United Nations Children's Fund to be represented when considering the implementation reports. The Committee may invite them and other competent bodies to provide expert advice and implementation reports. It also gives them state reports which request for or need technical advice or assistance, along with its observations and proposals. Clearly, the right to health for children in Uganda is well catered for under the CRC.

e. The Convention on the Rights of Persons with Disability (CRPD, 2008)

Article 3 of the CRPD lays down the general principles of non-discrimination, full and effective participation in society and equal opportunity. Article 15 prohibits torture, cruel, inhuman or degrading treatment or punishment against people living with disability (PWDs), while Article 17

protects their physical and mental integrity. Article 23 entitles PWDs to marriage, family and parenthood including the right to retain their fertility and to practice their own family planning. Article 25 entitles PWDs to enjoy the highest attainable standard of health without being subjected to any discrimination. It obliges the State to provide PWDs with access to health care, insurance, food, fluids and rehabilitation that are affordable, gender-sensitive, and of the same quality and standard as those for other individuals. It also requires the state to provide services tailored to the needs of PWDs, including early diagnosis and interventions that limit the development of further disability (UN, 2007).

Addressing the issue of implementation, Article 4 of CRPD obliges the State to ensure and promote the full realisation of the rights and freedoms of PWDs by adopting appropriate legislative and administrative measures and by consulting with PWDs. In addition, Article 31 charges the State to collect appropriate information, including statistics and study, to enable it to formulate and implement relevant policies, as well as recognise the importance of global partnerships in supporting national efforts to realize the CRPD objectives, including synergies with relevant international and regional organisations and civil society. Examples of such efforts are the inclusion of PWDs in development programmes, capacity-building, sharing experiences and best practises, collaborative study and access to scientific knowledge.

Article 33 further provides for national implementation and monitoring by requiring the State to designate focus areas of government to enforce the rights and duties established in the CRPD. The State is also given the mandate to design, strengthen, or establish a framework to promote and protect adequate project implementation. Article 33(3) specifically calls for the full participation of civil society in the monitoring process. Finally, at international level, Article 34 of the CRPD establishes the Committee on the Rights of Persons with Disabilities, which is composed of twelve to eighteen experts of highly moral and recognized competency. According to Article 35, the State must submit a comprehensive report on its implementation measures and progress to the Committee every four years and whenever the Committee requests so. This submission must be done through the United Nations Secretary General.

Article 35(4) and (5) implores the State to prepare the reports in an open and transparent process. Article 36 allows the Committee to request further information from the State regarding its implementation and to make general recommendations to which it is not mandatory for the State to respond. Finally, Article 36(4) requires the State to make its reports available to the public and to facilitate the access to the Committee's recommendations.

f. Uganda also signed and ratified the WHO Framework Convention on Tobacco Control (FCTC) in 2005 and 2007 respectively and is therefore obliged to have a comprehensive Tobacco Control Act which was gazetted in 2015 (WHO, 2003)

g. Uganda has not ratified the most recent and updated ILO Maternity Protection Convention 183, (ILO 2000) but it has expanded provisions for maternity protection notably in extending maternity leave to sixty working days (12 weeks) within the Employment Act No. 6 of 2006 up from 6 weeks (Republic of Uganda, 2006). This is still far below the recommended minimum of 14 weeks, but the act provides for paternity leave (for the husband) in the event that the wife has gone through child birth or had a miscarriage. Uganda is one of 29 countries, which had adopted laws that provide an absolute prohibition against the dismissal of a worker during maternity leave for any reason (ILO, 1998).

3.2 Regional instruments and continental and sub-continental level

a. *The African Charter on Human and Peoples Rights (ACHPR)*

In Africa, the ACHPR is the principle human rights protection tool. Oversight and interpretation of the Charter is the task of the African Commission on Human and People's Rights, which was set up in 1987 and is now headquartered in Banjul, Gambia. The latest protocol to the Charter came into effect in 2005. Article 4 of the ACHPR declares every person inviolable in virtue of the right to life and integrity. Article 16 confers on each individual a right to the highest attainable state of

physical and mental health. Article 16(1) of the African Charter on People's Rights provides that, "Every individual has the right to enjoy the highest attainable state of physical and mental health." Article 16 (2) obliges state parties to the African Charter to take "the necessary measures to protect the health of their people and to ensure that they receive medical treatment when they are sick". Article 18 requires the State to protect the physical health of families and to protect the rights of women and children as per international declarations and conventions. An example of the application of these rights is present in the case *Egyptian Initiative for Personal Rights and Interights v Egypt*, where the African Commission found that when Egypt failed to protect four female journalists from state violence and failed to provide them with medical attention and forensic examinations during the interrogations related to the Taba Bombings, it violated their human rights to equality, non-discrimination, dignity and freedom from cruel, inhuman and degrading treatment (OAU, 1982).

Women's rights are specifically addressed in the Protocol on the Rights of Women in Africa, which was established under the ACHPR. Article 14 of the Protocol provides for the health and reproductive rights of women and empowers them to control their fertility, and the number and spacing of their children. The Article further obliges the state to take appropriate measures to establish and strengthen existing pre-natal, post-natal health and nutritional services during pregnancy and breastfeeding. The Protocol also protects women's reproductive rights by authorising abortion in cases of sexual assault, rape, incest and where the pregnancy endangers the mother's physical and mental health. Uganda is signatory to this protocol but with reservation on this specific article 14(2)(c) relating to abortion. Furthermore, Article 18 of the Protocol provides for a healthy and sustainable environment, which is essential to the wellbeing of pregnant women and new-borns.

The foregoing provisions are inextricably linked, interdependent and indivisible. The African Commission advocates for the broad interpretation of the Protocol and encourages the consideration of other relevant issues for women's rights such as human dignity, equality, security, access to justice and education in General Comment No. 2, para 7 and 38 (AU 2003). General Comment No. 2 on Article 14 of the Protocol elaborates on the causes of maternal mortality which include preeclampsia, post-partum haemorrhage, obstructed delivery, puerperal sepsis and complications resulting from abortions undertaken in inadequate conditions (Adopted at the 55th Ordinary Session, 2014 in Luanda, Angola). For example, Preeclampsia affects 5-8% of all births in America and 4-18% of all births in Africa (Villar et al, 2003). The Protocol reflects the challenges faced by the African population and simultaneously points to priority areas for its better development.

Article 25 of the African Charter addresses rights implementation by obliging the state to use education and accessible publications to promote human rights. Article 26 requires the State to guarantee the independence of courts and support the establishment and improvement of appropriate national institutions entrusted with the promotion and protection of rights and freedoms. Article 30 established the ACHPR to promote and protect rights, interpret Charter provisions and perform other tasks assigned by the Assembly of Heads of State as stated in Article 45 (OAU, 1982). As a safeguard, Article 61 allows the Commission to consider general principles of law, precedence, other international conventions, and international norms and customs accepted as law. Article 62 ensures state accountability by requiring countries to submit a report every two years on the legislative measures taken to implement human rights. This provision has often been considered as being problematic as countries struggle to submit reports in a timely manner. According to the ACHPR website at <http://www.achpr.org/states/reports-and-concluding-observations/> , Uganda has submitted five reports to the commission. The 5th report (2010 – 2012) was submitted in September 2013 and two reports (2012 – 2014; and 2014 – 2016) have not been submitted. The Article's effectiveness largely depends on the citizens active monitoring of its government's actions and of the report's authenticity.

Some instruments were specifically created to be applied in East African countries and also include provisions that are relevant to the protection of the right to health in Uganda. For

example, Article 117 of the Treaty for the Establishment of the East African Community (EAC) obliges the partner states to co-operate in various matters including health. Article 118 enjoins the partner states to promote the management of health delivery systems to enhance the efficiency of their health care systems. The Treaty further charges the partner states to promote the harmonisation of national health policies and regulations, and cooperation in the development of specialised health training, study and reproductive health (EAC, 1999).

Pursuant to Articles 118, 127, 128 and 129 of the Treaty, the East African Health Platform (EAHP) was formed as a collaborative space for representatives of Private Sector Organizations (PSOs), Civil Society Organizations (CSOs), Faith Based Organizations (FBOs) and other interest groups of East Africa to effectively drive sustainable health and development in the region. The EAHP vision is of a healthy and productive population which enjoys local quality and affordable health care within the region. Efforts made towards bringing this vision into reality are found in projects such as their 5 year maternal infant health strategy aimed at reducing maternal and new-born mortality rates in East Africa by 2020 (Ligami, 2015).

The Treaty has a second implementation branch called the East African Health Study Commission. The Commission established the Regional East African Community Health Platform Policy Initiative (REACH) in 2005, which induced Uganda into publishing policy dialogue reports (WHO, 2014). Other regional initiatives include the enactment of the East African Community HIV and AIDS Prevention and Management Act in 2012 and the formulation of the regional intellectual property policy on the utilisation of public health-related WTO-TRIPS flexibilities and the approximation of national intellectual property legislation (CEHURD, 2018).

Overall, the international and regional treaties Uganda is involved in strongly emphasize the importance of the right to health. They have often encouraged Uganda to make national efforts towards health care services but have yet to create enough pressure on the government for significant positive change to occur. The international community's arrangements to make the right to health a reality across the globe are essential for its implementation, but must be accompanied by significant local action from national member states.

3.3 The right to health and Ugandan law

Uganda has had a turbulent constitutional history deeply rooted in militarised politics. In the precolonial era, the country was organised and governed along tribal kingdoms headed by cultural leaders such as the Kabaka of Buganda and Omukama of Toro and Chiefs in the north and east. In 1894, Uganda became a British Protectorate and the kingdoms signed power agreements with the British (Examples include the 1900 Buganda Agreement and Toro Agreement; the Ankole Agreement, 1903; the Bunyoro Agreement, 1933; The British legislated by way of Orders in Council, 1902 and 1920). In 1902, the British passed the Uganda Order in Council which set up a centralised system of governance, which included a legislature, judiciary and executive to govern the whole country (Mukholi, 1995)

In 1962, Uganda became independent with a new Constitution that entrenched federalism. In 1966, the Prime Minister Milton Obote abrogated the Independence Constitution, declared himself President under an Interim Pigeon Hole Constitution, and mandated Parliament to draft a new constitution. In 1967, the Republic Constitution was introduced, abolishing kingdoms by restoring centralized governance (Constitutionnet, undated). In 1971, General Idi Amin seized power and ruled by constitutional decrees until 1979 when he was ousted by a coup d'état. In 1985, Milton Obote was re-elected president, but was expelled in 1986 by the National Resistance Movement which enacted Statute 5 of 1988 and embarked on a constitutional reform by an elected Constituent Assembly (Constitutionnet, undated). All of these constitutions did not include the right to health.

In 1995, the current constitution was promulgated. It made unseen efforts to recognize human rights and freedoms in Uganda. However, like its predecessors, it ignored several social economic rights such as the right to health, and tucked it in the national objectives and directive

principles of state policy which guide policy development and implementation. However, it did not define the standards of enjoying the rights which are justiciable (Uganda Constitutional Court, 2012). Substantive provisions, such as Chapter Four, introduced a bill of inherent rights not granted by the State (Republic of Uganda, 1995a). They specifically guarantee the right to life, to a clean and healthy environment as well as freedom from discrimination and torture, but not the right to health. In 2005, the Constitution Amendment Act was passed and introduced several changes, including Article 8A, on national interest, which bolstered the justiciability of the national objectives and directive principles, and Article 32(2), which reinforced affirmative action for women.

This section analyses the national Ugandan laws that are applicable to the right to health. It then examines the role of the current constitution in the realisation of the right to health, within the broader context of the international and regional laws mentioned in the previous section and which Uganda has domesticated.

a. The 1995 Constitution

The Constitution of the Republic of Uganda is the supreme law of the land and any law, culture or custom contrary to it is void to the extent of its inconsistency as cited in Article 2 of the Constitution (Republic of Uganda, 1995a). The Constitution takes precedence over all laws and all health laws must thus adhere to its provisions or else it may be nullified. For the first time in Uganda's history, the 1995 Constitution ushered in a bill of rights which guarantees Ugandans their inherent entitlements. However, it does not expressly stipulate the right to health. Instead, the constitution has a number of health-related provisions, which are discussed in the following section. Since 2005, Article 8A requires the state to be guided by national objectives and directives of state policy in applying or interpreting the constitution. Previously, the Ugandan courts held that national objectives were not justiciable, but scholars argue that Article 8A now renders them legally binding and enforceable. (Uganda Constitutional Court, 1999; Mbazira, 2008). Accordingly, judicial views have evolved to recognize that government has a negative obligation to respect the rights and embrace cases to determine whether state affirmative duties are fulfilled to allow for the realisation of rights (Soohoo and Goldberg, 2010). For instance in the landmark case of David Mugerwa vs. A.G & Others, the Court explicitly held that the right of the deceased mother to basic medical care was violated by the district hospital due to its failure to provide emergency obstetric care (Uganda High Court, 2012). This requirement for appropriate maternal health care delivery is based on several provisions: Objective XIV on social and economic objectives, Objective XV which recognises the role of women in society, Objective XX on the state's duty to ensure the provision of basic medical services to the population, Objective XXI which provides for clean and safe water at all levels and Objective XXII which provides for food security and proper nutrition. The substantive constitutional provisions of the right to health in Uganda include the following:

- Article 20(1) declares human rights as including those that are inherent and not granted by the state. Specifically, Article 20(2) imposes a duty on all government organs, agencies and persons to respect, promote and uphold every human right including health related ones. This is the premise for the implementation of the constitutional right to health as it creates obligations for both public and private duty bearers. These obligations are reinforced by Article 21(4) which guarantees that no provision against discrimination prevents Parliament from enacting laws necessary for the implementation of policies and programmes aimed at redressing any imbalance in society or providing for any matter acceptable and demonstrably justified in a free and democratic society. The obligations set out above are threefold. The duty to respect human rights is a negative obligation which requires the state and all persons to refrain from interfering with the enjoyment of the right to health. The duty to promote is a positive role which requires the government to create an enabling environment for the realisation of the right to health. Such efforts include legislative, administrative, judicial and financial advancement of the right. Finally the duty to protect is also positive and necessitates the state to shield the right to health from violating acts by third parties. For instance, the

state has a duty to censor the production of restricted drugs, ban compulsory labia elongation in boarding primary schools and smoking in public spaces.

- Article 21(1) provides for equality before and under the law in all spheres of life. Article 21(2) prohibits discrimination on grounds of sex, birth, religion, social or economic standing, or disability (Article 21(3)). Any of those parameters can affect the enjoyment of one's right to health as later discussed in chapter three. In the case of *Law and Advocacy for Women (Uganda) v Attorney General* (Constitutional Petition No.6 of 2005), the petitioners successfully challenged the constitutionality of sections in the Penal Code Act which criminalised adultery against women but not men (Republic of Uganda, 2005). The Court found the sections were discriminatory and offended Articles 2 and 21 of the Constitution, and declared them void. Quite interestingly, Article 21(5) allows anything permitted under the constitution to favour certain groups and to be applied differently across groups. For instance if any initiative is preferentially undertaken to boost access to and affordability of health services in remote or poorer areas, those in more privileged locations cannot deem such corrective action as discriminatory, since it is permitted by the same constitution.
- Article 22 protects the right to life of all, including the life of an unborn child, by prohibiting its unlawful deprivation. This article's effect is that a loss of life caused by a wilful procedure (e.g. abortions, executions ordered by a competent fair following a fair trial) must be done according to a specific law passed by Parliament. All other deaths arising out of ill-health including maternal and child mortality are contrary to the constitutional right to health and life. As it stands today, Parliament has not fulfilled its duty to legislate and legitimise abortion under justifiable circumstances. Instead, the Penal Code Act under Sections 141, 142, 143 and 212, criminalizes abortion and penalizes any person, including mothers and health workers who unlawfully enable the termination of a pregnancy. Consequently, women risk engaging in undercover and risky abortions without professional health care out of fear of being prosecuted for murder. However, Article 14(2) of the Women's Protocol to the ACHPR legalized safe abortion under justifiable circumstances, and enjoined the state not to criminally prosecute or punish women who so abort, as well as exempt health workers from prosecution or disciplinary reprisal when they provide abortion and post-abortion services to protect women (AU 2003). Such cases of authorized medical abortion include pregnancy arising from sexual abuse, incest and endangered health of the mother or unborn child. In a similar spirit, the Uganda National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights 2012 recognises when a pregnancy threatens life, and caters for the management of access and use of safe abortion and the prevention of unsafe abortion (Mulumba et al., 2017). Such cases include severe cardiac or renal disease, Preeclampsia, Eclampsia and foetal abnormalities incompatible with extra-uterine life which are also a lawful defence under Section 224 of the Penal Code Act (Mulumba et al., 2017).
- Article 23 further prohibits the deprivation of personal liberty, except in specified circumstances which include quarantines instituted to prevent the spread of an infectious or contagious disease, restraining a child for their welfare or restraining a person reasonably suspected to be mentally ill or addicted to drugs or alcohol, so as to care or treat them or to protect the community. In this instance, the need to enforce the right to health becomes the basis for limiting the right of the affected person from enjoying their personal liberty. This article confirms that good health is a prerequisite for the full enjoyment of other rights, thereby proving the complex interdependence between human rights. A more practical illustration of the intersection of the rights to health and personal liberty is when hospitals detain patients who fail to pay their medical bills (News of Africa, 2017). Constitutionally, such healthcare providers violate Article 23 of the patient's freedom of movement, yet, contractually, their constitutional right to derive livelihood from one's profession under Article 40 and the contractual right to receive sufficient consideration for the medical care provided is also breached by such patients. Such detentions therefore constitute prisons for indebted patients, which, in turn, greatly harm the new-born's post-natal health. However, it is still unclear whether this practice is illegal since Article 23(1)(h) allows for the restriction of the

right to personal liberty in a variety of general circumstances. Future case law is likely to elaborate on this unexamined constitutional tension.

- Article 24 provides for the respect of human dignity and freedom from torture, cruel, inhumane and degrading treatment. Despite this provision, pregnant women continue to be treated in cruel, inhumane or degrading ways, even at the hands of health service providers. In the case of *Joyce Nakacwa v Attorney General & 2 others* (Constitutional Petition No.2 of 2001), the petitioner delivered a baby by the roadside near Naguru Hospital. She proceeded to the Maternity Clinic with the baby still attached to her after birth to complete the birth process but received no medical care and was instead referred to Mulago Hospital without a referral letter. She lost her baby and sued claiming that the hospital's denial to offer her a decent place to complete the birth process violated her right to freedom from torture and cruel, inhuman and degrading treatment. The court acknowledged that the medical worker's omissions contributed to the death of the child. Nakacwa's case highlights the torturous situations to which pregnant women are confronted to in the health care system (Uganda Constitutional Court, 2001).
- Article 26 protects the right to property and prohibits the deprivation of property except in the interest of public health, safety or order. Property rights are relevant to the right to health in so far as a patient is entitled to access and use essential medicine and other health facilities. The UN Assembly tasked states to ensure access to safe, effective, affordable and good quality medicines fundamental to the full realisation of the right to health (UN General Assembly, 2004). There are many challenges to the availability and accessibility of quality medicines, such as limited health infrastructures, budgetary allocations, procurement, distribution and use of medicine, and high prices for medicines due to high costs of production met by pharmaceutical companies to protect their pharmaceutical patents under the Agreement on Trade Related Aspects of Intellectual Property (TRIPS) (Twinomugisha, 2015). Property rights dictate social wellbeing in Uganda, which is tied to women's ability to exercise their maternal rights (Nyakato and Rwabukwalib 2015).
- Under Article 27, the Constitution guarantees the right to privacy by prohibiting unlawful searches and access to the person, their information or their property. This article lays the foundation for a bundle of professional duties of care owed by health personnel to their patients, such as maintaining confidentiality, and procuring informed consent from the patient to administer specific medical care. Similar caution must be exercised in the handling of patient records to avoid unauthorised disclosure of their health conditions. The article's breach thus amounts to professional negligence. Other common violations of privacy manifest themselves in moralistic religious and cultural circles. Examples include churches, school and parental homes where women or girls who become pregnant out of wedlock are stigmatised, forced to apologise in public and excommunicated from their communities for exercising their sexual and reproductive rights (Republic of Uganda, 1995a).
- Article 28 provides for the right to a fair public hearing for all civil and criminal matters before a competent, independent and impartial court or tribunal. The right to health is a civil right and its violation constitutes actionable wrongs in both civil and criminal law. The Ugandan courts have increasingly adjudicated cases on the right to health. Details of the relevance of a fair hearing to a high standard of health are further discussed in a later section.
- Article 29 guarantees freedom of expression, conscience, assembly, association and religion. These factors fundamentally influence whether and how one enjoys their right to health in so far as they determine the social, political and economic context of its application. For instance, freedom of expression and conscience determines whether a woman uses contraceptives, and if so, which ones. Likewise, free speech impacts the information women receive about their health because some topics such as sexual rights are taboo. Similarly, freedom of assembly, association and movement enable women to visit their health providers for maternity check-ups, counselling and post-natal care, while its constraint limits the

enjoyment of the right to health. Religion curtails the right to health through actions such as the proscription of contraceptives amongst some Catholics, or Pentecostals who demote and expel their ministers and flock for out-of-wedlock pregnancy to deter sexual sins (Republic of Uganda, 1995a).

- Article 30 provides for the right to education, which is highly relevant to the right to health as it is a powerful vehicle for information sharing. It can be used to inform individuals about health risks, prevention measures and best-health practices. It is also relevant to the right to health as it is essential in building a competent and skilled health work force aware of effective health strategies. Education may be formal or informal depending on the forum and avenues used to deliver the material. Formal education is regarded as the more credible and reliable source of health information and it may be provided by both the public and private sector, through the school curriculum right from elementary to tertiary levels and from professional health workers. In contrast, informal education sensitizes citizens through less structured avenues such as the media, music, drama and peer interactions. Unfortunately, the right to education occasionally supersedes one's right to health. The most common case is the expulsion and stigmatisation of female students from school when found pregnant (Lall 2007). Arguably, the student should stay in school to ease her access to information on her maternity. However, there are legal, public policy and morality imperatives which justify the exclusion of child or teenage mother from centres of learning (UBOS and ICF, 2017).
- Article 31 entitles every woman and man of full age to voluntarily found a family, and enjoy all marital rights on an equal basis. This provision is particularly progressive as it supports women's power to negotiate and make decisions about their sexual and reproductive rights (e.g., through family planning). It also empowers them to participate in their family wellbeing in matters such as nutrition, housing and sanitation without facing discrimination. In the case of *Best Kemigisa v Mable Komuntale & Another*, the Court found that the Tooro tradition which barred a woman from inheriting property on the basis of her sex was repugnant to the Constitution (Bagonza, 2016). This decision reaffirmed the rights of women to enjoy their property and make decisions for its use towards accessing quality and affordable health care. Equally, Article 32 provides for affirmative action and Article 33 stipulates the rights of women. Both viewed separately and combined, they prohibit any negative customs and practices that are against the dignity and welfare of women. In the case of *Maliyam Adekur & Another v James Opaja & Another*, the Constitutional Court held that the custom in Pallisa allowing widow inheritance went against the spirit of the Constitution (Uganda Constitutional Court, 1997). It is however important to mention that lawful cultures must be enjoyed and promoted under Article 37, as they are not oppressive and can be useful to the holistic development of individuals. For example, the role of Traditional Birth Attendants cannot be underestimated in rural areas as they provide affordable and accessible maternal health care. Thus, it is imperative to explore ways to preserve the services, knowledge and skills of reliable and effective Traditional Birth Attendants.
- Article 34 provides for the rights of children, including the right to be cared for by their parents. The welfare and best interests of the child are to guide every decision and action taken, as was established in *Re Justine Waiswa Bakama & Nauma Catherine Adongo (infant)* (Uganda High Court, 2014a). This is essential to maternal health because of the dependency of children on their mother's well-being, especially for infants who are still breast feeding. Equally, this provision can be used to safeguard mothers and their dependent children from being separated against their will, which is a common trend for teenage and rural mother, but perhaps not surrogate mothers (Republic of Uganda, 1995a).
- Article 35 protects persons with disability (PWDs) by entitling them to respect and human dignity, and by requiring that Parliament enacts additional protective laws according to their needs. An example of such a law that has yet to be adopted is one that compels all health centres to have ramps or lifts making them accessible for PWDs. In the case of *Legal Action for People with Disabilities v Attorney General & Others*, the applicants sought a declaration

that the respondent's failure to make their premises easily accessible to PWDs violated their fundamental rights (Uganda High Court, 2014b). The Court rejected this claim stating that it cannot order a prompt enforcement of the law because of the hardship that such enforcement would entail. This reasoning serves as a clear example of the predominant attitude which favours saving financial resources over facilitating PWDs access to affordable health services. Overall, PWDs face accessibility challenges every day that have yet to have been recognized by the Court and which constitute a threat to the country's health (CEHURD, 2016). Articles 32-35 are strengthened by Article 36 which provides for the protection of minority rights and end the tyranny of numbers. Of course, PWDs are not the only minority, although the Courts are yet to develop a universally accepted definition of a minority group in the context of Uganda. This subjectivity in the face of wide judicial discretion to dismiss cases raises the evidential burden and standard of proof for whoever seeks to assert their health rights as a minority. Accordingly, this is another area of further investigation into what constitutes minority rights in Uganda, and how minorities can assert their constitutional right to health based on their unique circumstances.

- Article 39 of the Constitution provides for the right to a clean and healthy environment, a precondition to the enjoyment of health. This right can be maintained through proper hygiene and waste management. For instance, pregnant woman should have the right to deliver and raise their children in a clean and healthy environment with access to clean water and air. An effort to enforce this right in relation to health was exemplified in *The Environmental Action Network v British American Tobacco*, where the applicants sought a declaration that the respondents failed to warn customers of the health risks of smoking and the Court issued an order to compel them to place warning labels on its packs and advertising materials (Republic of Uganda, 1995a).
- Article 40 provides for economic rights and requires that Parliament enact laws to ensure that all people work under satisfactory, safe and healthy conditions. When applied, this article entitles workers to protective gear in the work place, compensation for harm caused by occupational safety risks, job security, paid maternity and sick leave and protection from termination due to pregnancy. The latter is a common practice for employers, especially for those from the private sector. In the case of *Salvatori Abuki v Attorney General*, the Court held that an individual's means of livelihood can be associated to the right to life, with the understanding that once that means of livelihood is terminated, there is no life left to protect (Uganda Constitutional Court, 1997). Furthermore, when an individual is dismissed from their work, one can argue that their right to own property was taken away from them. Article 40 thus provides for some elements of a right to health but is limited in application to employees in the workplace. Individuals should, however, be protected and have access to the right to health in all spheres of their lives. The lack of a general right to health cannot be justified by the presence of Article 40. In cases of a breach of Article 40, Article 42 is also often evoked as it provides for the right to just and fair treatment in administrative decisions.
- Article 41 provides for access to information. This is an effective tool for citizens to request information from their government on the performance of their services and hold them accountable to the resources allocated to the health sector. It is also the basis for powerful sensitisation means such as access to educational information on topics including family planning, nutritional foods, warning signs of disease and accident prevention. This information sharing contributes to empowering citizens into making informed decisions about their health and well-being.
- Article 43 is of a particular interest because it establishes general limitations on the enjoyment of all rights, which include interests of public health and safety. In doing so, it establishes public health as a national priority with the potential to justify the violation or restriction of a constitutional right. Considering that the constitution is silent on the overall right to health, including public health as a possible ground for a right limitation is a significant stride in grounding health as an inherent and superior right under the constitution.

- Article 45 states that the fundamental human rights and freedoms not specifically mentioned under the Bill of Rights shall not be taken as to exclude other rights that are not expressly provided therein. This is another progressive provision which reinforces the duty to observe, promote and enforce the constitutional right to health in Uganda, despite the fact that it is not expressly provided in the constitution. This article reaffirms the existence of the right to health.
- Articles 48 to 51 establish institutional recourse avenues for cases where the right to health is violated. These matters are under the jurisdiction of the High Court of Uganda and the Ugandan Human Rights Commission (UHRC). Individuals whose rights have been violated can seek redress through litigation and review procedures in these courts.

b. National Legislation

- Uganda has a collection of laws which complement the constitution or fill in some of its gaps. Article 79 of the Ugandan Constitution mandates Parliament to make laws for the peace, order, development and good governance of Uganda. This provision establishes Parliament as the primary legislator. For each act proposed by Parliament to have the force of law, it must be approved by the President and must conform to the Constitution. A series of acts are dedicated to the protection, fulfilment and respect of the right to health. For instance, the Food and Drugs Act, Cap 278 focuses on preventing food and drug alterations that are unsafe for human consumption and the Water Act, Cap 152 governs the use, protection and management of water resources. Another category of acts focuses on the state implementation of Parliament's constitutional duties by establishing public agencies responsible for providing health services. Some examples include the National Medical Stores Act, Cap 207 which established the country's hub for efficient and economical procurement of quality medical supplies for public health services. There is also the National Drug Policy and Authority Act, Cap 206, which set up an authority to ensure the availability of efficacious and cost effective drugs, and the National Environment Act, Cap 153, which oversees the management of a clean and healthy environment in line with Article 39 of the Constitution (Republic of Uganda, 1959; 1993a; 1993b; 1995a; 1995b; 1997a).
- Health workers have laws that govern them in their different categories. The Uganda Medical and Dental Practitioners Council (UMDPC) regulates the conduct of all medical and dental practitioners in Uganda guided by the Medical and Dental Practitioners Act, Cap 272. The Council has a code of ethics which spells out the obligations that health workers have in the protection of human rights. The Uganda Nurses and Midwives Council (UNMC) similarly is regulated by the Nurses and Midwives Act, Cap 274 which requires nurses and midwives to protect human rights. The professionals have ethical codes set out standards through which human rights can be protected. The Code of Ethics for medical and dental practitioners for example under Rule 4 requires medical and dental practitioners to respect and protect human rights but phrases their respective obligations as ethical responsibilities (Republic of Uganda, 1996; 1998).
- Health workers in the public sector are collectively regulated by the Health Service Commission which was created under the Health Service Commission Act of 2001 (Republic of Uganda, 2001). The act recognizes the duty of health workers in relation to rights of patients by phrasing them as responsibilities. The Act recognizes the duty of health workers to act in the best interest of patients at all times, to ensure informed consent, respect the privacy and confidentiality of a patient, avoid conduct detrimental to the community and abide by all laws and regulations governing their professions. However, the law is silent on the rights of health workers as well as the Patients' Right Charter, though the Charter clearly specifies the rights of patients including the right to emergency medical care, the freedom from discrimination, the right to a clean and healthy environment, the right to participate in decision-making and the right to medical information among others. Unfortunately, the provisions of the Patients Charter are limited in effect because they do not have binding force of the law and can only be applied at the health worker's discretion (AGHA undated).

While there are many laws that advance the right to health, there are still others that are old laws, with gaps in relevant provisions on this right.

- The Public Health Act of 1935 (amended in 2000) is very old and is not anchored on human rights principles. It focuses primarily on the control of sexually transmitted infections and the nature of sexual offenses against vulnerable groups (Republic of Uganda, 1935). The sexual offences bill has been in place for the last two years but has faced resistance by many law makers
- The HIV and AIDS Prevention and Control Act of 2014 is reported to have commendable provisions and presents an opportunity for intensifying response to a global health security crisis (Republic of Uganda, 2014). The act advances pre-test and post HIV counselling; voluntary HIV testing; state responsibility in HIV control; Legislation against discrimination in access to employment and other social opportunities on the grounds of HIV status, and creation of the AIDS Trust Fund. After the law was passed, a number of civil society organizations arose to contest certain clauses of the law, including mandatory testing of pregnant women and their partners, and disclosure of HIV status of a client by health workers to people who according to the health worker are at risk of being infected by this client. This contest led to a constitutional petition No. 24/ 2016 challenging discriminatory HIV Criminalization Legislation (UGANET, 2016).

3.4 Summary of the findings

The section reviewed the legal instruments influencing the constitutional right to health and which Uganda is party to at global, regional and national levels. Various legislative frameworks that establish the indivisibility and interdependence of human rights, including the right to health, were found. Their substance and form presented both a wealth of opportunities and challenges in the implementation of the constitutional right to health.

The international laws expressly guarantee the right to health. They elaborate its prerequisites, components and the standard to which it should be enjoyed. They further impose obligations on various stakeholders such as the state, individuals, civil society and international community to promote and implement the right. Furthermore, they buttress the right to health by providing for other supportive rights and freedoms such as life, equality, dignity and access to information, thereby creating an increasingly enabling environment for implementation.

Regionally, the text of the East African laws does not categorically mention the right to health. However, their various provisions commit the state to ensuring more efficient delivery and management of health services using different legal, institution, policy and administrative mechanisms. In reality, this is gradually translating itself into policy implementation, but there is a great need to intensify the benchmarking of laws and best practices towards harmonising the right to health in the region. For example, a clear gap is that Kenya's constitution mentions the right to health, whereas Uganda's is still silent in this respect, yet both states actively participate in the EAC health programmes. Locally, the current Constitution of Uganda is criticized for its silence on the right to health. However, it has provisions which affirm the existence and enforceability of the right despite the imprecision of the text. In addition, Uganda is a signatory to multiple international and regional laws which expressly stipulate the right, among other health related rights, and demarcates clear obligations of the state parties. Thus Uganda has a sufficient legislative regime within a diversified human rights framework to recognise and implement the right to health, to the standard set as well as to hold the state accountable for its duties.

Fortunately each convention clearly stipulates the mechanisms of implementation by the state and accountability through filing periodic reports. The opportunity here is for individual citizens, CSOs and the international community to consistently monitor the government's compliance with the implementation and reporting frameworks so that the law translates into actual health. Further, based on the regional frameworks, there are institutions charged with interpreting and enforcing the right to health. The task remains for citizens as rights holders to make use of the commissions and committees to ensure that they compel government to deliver on its

expectations. The institutions have demonstrated openness to engage and take decisive positions on the right to health and their decisions are binding. The likely challenge here remains the cost of litigating in the regional and international forums, as well as Uganda evasively asserting that it is a sovereign state not bound by international orders.

Nationally, there is a limitation that the constitution is not explicit in guaranteeing the right to health. However, it extensively provides for health related rights which are justiciable and are direct basis for implementing the right to health. Moreover, the constitution recognised that some rights may not be manifest in the text but they are still existent and enforceable. The constitution also establishes obligations for both the state and the citizens, individually and collectively. First, it categorically obliges government as a whole to promote, protect and uphold the rights. Secondly, it details the duties of each arm of government in rights enforcement. Thirdly, it also tasks the citizens individually and under civil society organisations to observe human rights and report violations when threatened or actually violated. Further, the Constitution establishes enforcement avenues through institutions such as the Courts, the Uganda Human Rights Commission, policies, programmes and legislative powers of parliament. However, since the Constitution is the supreme law, it does not detail the implementation mechanisms or how to hold the duty bearers and rights holders accountable. However, very few cases have been reported at the international and regional level from Uganda in respect of the right to health, and more so maternal health care.

In sum, Uganda has sufficiently law to recognize and implement the constitutional right to health, although gaps remain. It thus appears that Ugandans need to be more pragmatic to harness the international and regional laws and institutions to promote and enforce the right to health at home. In addition, more vigilance is needed to hold government and other stakeholders accountable in reporting and delivering quality health care services in Uganda. There is a need to further tap international cooperation to better aid the realisation of the right to health in Uganda. These measures for implementation are further explored in the next section.

4. Implementation of the right to health

There has been limited legal study to verify the efforts made to constitutionally implement the right to health, which is the focus of this section. It is important to go beyond the foregoing collection of provisions in order to access how they translate themselves into actions closer to the daily lives of Ugandans. Each provision is applied and interpreted differently by the politicians, judiciary and population, which will each be considered below.

Uganda's history strongly defined the current efforts in the implementation of the right to health. In the pre-colonial era, Uganda had no formal health system as most people relied on traditional knowledge and caregivers such as midwives for medical services. The colonial regime led to the development of several religious founded hospitals such as Mengo, Kibuli Rubaga and Kitovu. They are known to having been managed by religious groups but to date still support the governmental delivery of healthcare. Post-colonial Uganda has been marked by instability due to civil wars which led to poor and inefficient health service delivery characterized by insufficient funding, gross drugs and medical supplies shortages, and infrastructure breakdowns.

In the 1990s, Uganda was ravished by the HIV/AIDS scourge and the government embarked on health sector reforms such as emergency rehabilitation, infrastructure revamps and disease control to improve mass sensitisation, access and use of medical services in partnership with international donors. Private efforts also supplemented their initiatives as health related advocacy and litigation by CSOs and lawyers intensified and investors embraced economic liberalisation to build private hospitals and offer diversified services (De Torrente, 1999). Such efforts paved the way for realising the constitutional right to health in Uganda through the three common approaches of political, judicial and popular implementation.

4.1 Political implementation

Political actions play a significant role in bringing a constitutional right into practical initiatives. The 1995 Constitution of Uganda sets up three branches of government, the legislature, the executive and the judiciary, each with a distinct mandate exercised by the doctrine of Separation of Powers. The executive is the administrative arm that formulates policy for implementation alongside the constitution and other laws (Articles 98 and 99 of the constitution; Articles 111 - 114). The legislature is mandated to make laws (Article 79 of the constitution; Article 77 of the constitution) and the judiciary adjudicates over conflicts (Article 126; Article 128) (Republic of Uganda, 1995a). Each arm uses its authority while being subject to checks and balances with the others. For instance, Parliament checks the executive's powers by vetting presidential nominations for ministerial roles, while the President has to assent to bills passed by the legislature before they become binding. Similarly, the executive appoints the judiciary which interprets Act of Parliament and determines their constitutionality with the power to declare the repugnant ones void. For example, in the case of *Oloka Onyango & Others v Attorney General*, the Constitutional Court declared the Anti-Homosexuality Act unconstitutional and void because it was passed without parliamentary quorum (Uganda Constitutional Court, 2014). In so doing, these controls ensure that each arm does not exceed its powers by acting *ultra vires*.

The political will to create and enforce policies that support the enforcement of the right to health is a factor in the constitution's implementation. Administratively, the executive must formulate policies that facilitate the constitution's political implementation. An example of such initiatives is the Human Rights Based Approach (HRBA), which has put in place several strategies to the state fulfilling its obligations in the health sector. The following section examines some key strategies and policies that demonstrate the current political constitutionalism in Uganda.

The executive's actions are guided by Uganda Vision 2040, which provides direction to all governmental initiatives that aim to the fulfilment of its duties and responsibilities including the provision of healthcare (National Planning Authority, 2013). Most importantly, for Uganda's human rights advocates, is the framework's acknowledgement of the state's obligation to respect and promote human rights. It also commits the governments to ensure that Human Rights Based Approach (HRBA) be developed in policies, laws, and programs to strengthen government officials' capacity to respect and protect human rights. Furthermore, Vision 2040 highlights that good health is instrumental to a society's socio-economic transformation, condemns Uganda's health sector's slow growth and attributes it to the current facility-based service delivery system. Hence, it calls for a paradigm shift towards a household-based health service delivery system which would promote health practices and lifestyles in order to empower households and communities to take control of their health. The Visions' implementation plan is divided in ten-year development plans. Uganda is currently implementing the Second National Development Plan (NDP II), which runs from 2010 to 2020 (National Planning Authority, 2015).

NDP II seeks to achieve the aspirations of Vision 2040 by ensuring the accessibility of quality health care to all people in Uganda. To do so, it has set several targets that must be reached to achieve this goal. For example, it aims to increase the percentage of child deliveries that are performed in health facilities from 41% to 64%, to reduce the ratio of inter facility maternal deaths from 148/100,000 to 119/100,000 and to reduce the ratio of deaths among under 5 year olds in health facilities from 18/1000 to 16/1000 by 2020. This plan builds on NPD I's achievements, which were mostly done in poverty eradication. NDP II differs most noticeably from the previous plan because of its emphasis on the role of public-private partnerships in the provision of private medical care and facilities (National Planning Authority, 2015).

NDP II stresses the need to practice good governance principles in the creation of a legal and socio-political environment favourable to an accelerated economic and social transformation. It is such an advocacy tool for constitutional democracy, the protection of human rights, and a free and fair political and electoral process. Paragraph 614 of NDP II declares that the interpretation of what constitutes governance goes beyond the public sector and extends itself to all stakeholders' whose participation is necessary to the promotion of good governance in Uganda.

It is clear from its goals and provisions that NPD II succeeded in setting clear targets towards the realisation of the right to health as part of the principles of good governance (National Planning Authority, 2015).

The National Health Policy, 2010 (NHP II) differs from the NDP as it has its own development framework, which focuses on health and seeks to implement the Health Sector Strategic Plan's (HSSP's) human rights commitments (MoH, 2010). Similarly to the NPD, the HSSP recognizes health as essential for the creation of sound development policies. It was the first plan to be set out under the national health planning framework and to expressly require the government to investigate in the promotion of health and nutrition for all and to consider it as a fundamental human right. It was also Uganda's first attempt to provide for the universal realisation of the right to health through the provision of a Ugandan National Minimum Health Care Package to all citizens (MoH, 2010). An additional framework, the National Health Sector Development Plan, was developed in 2015 to further these initiatives (MoH, 2015). Nevertheless, the reality remains that hardly any Ugandans make meaningful use of the National Minimum Health Care Package. Most of the employed citizens in the urban communities access health services medical insurance schemes put together by their employers. The most privileged also buy health insurance and pay out-of-pocket when the need for medical care arises. This leaves the majority of the Ugandan population, especially those who are poor and in remote rural areas, with very limited access to affordable and quality basic health care. Overall, although efforts have been made in the creation of numerous formalities, considerable additional efforts must be made to improve the daily life of Ugandan citizens.

The National Health Sector Development Plan provides for the health sector's midterm strategy and elaborates on the ways in which it will contribute to the realisation of NDP II, NHP II and the overarching Vision 2040 (MoH, 2015). The Plan states that in addition to national duties, the state has global commitments from international treaties and the SDGs. Guided by these international goals, the Plan identifies priority issues, including the production of healthy human capital through equitable, safe, and sustainable health services, addressing the social determinants of health, increasing the family's financial risk protection and enhancing competition in the health sector. It also reports that some progress has been made in ensuring that key policies and strategies recognize gender. These objectives can be interpreted to reflect aspects of a Human Rights-Based Approach (HRBA), such as participation, accountability, and equality along with the Availability, Accessibility, Acceptability and Quality (AAAQ) framework. However, the human rights are not explicitly provided for, and as implicit are subject to varied interpretation which may not necessarily reflect their importance.

On the other hand, the Plan has put together promising strategies focussing on gender and human rights. It reports that progress has been made in ensuring that key policies and strategies recognize a larger number of sexual orientations and address health in the context of human rights. This was mostly achieved by the government's creations of gender and human rights desks, guidelines for the management of gender based violence and a human rights and gender manual for service providers and policy makers.

Hence, the described strategies illustrate the presence of governmental efforts in mainstreaming the HRBA in health care provisions. However, the main challenge remains of translating HRBA into actual health care service delivery systems, further recognized by the Plan. Indeed, this study found significant disparities between the formal commitments made on paper and the actual governmental allocation of financial and human resources in the implementation of HRBA strategies and policies. Future efforts must therefore be made in going beyond formal commitments, introducing the implementation of constitutional provisions on the right to health in practice and not only in theory, and in moving towards tangible changes amongst communities. A first step in doing so could be ensuring that adequate human and financial resources are made available to health care institutions to allow for the proper delivery of services, as this is a recurring issue in national health law cases.

The government institutional structures used to formulate and implement the above policy architecturally are the two main levels of the executive, that is central government and the local government.

a. The President's office

Articles 98 and 108 of the Constitution created the Office of the President and Vice President. Their duty is to offer overall leadership, public policy management, promote good governance in public institutions and effectively support Cabinet to formulate and implement policies. Specific to health, the Office of the President includes a mandate to coordinate all agencies fighting the HIV/AIDS Pandemic (Office of the President, undated). At the time of the study, there was no specific coordination or regular monitoring found in respect to health by the highest office in the land. For instance, in November 2017, during the course of the study, doctors and medical interns suspended their services in public hospitals for a fortnight, which brought the health care system to a standstill where patients could not obtain treatment. The Minister in charge of the Presidency then issued a circular compelling all Resident District Commissioners to step up their supervision and monitoring of all health care centres and hospitals in their districts by submitting incidental reports of the number of health workers, their reporting times, services rendered and medicine quantities availed by NMS every month and quarter (Ainebyoona and Lubowa, 2017). Such haphazard monitoring and enforcement, which is incident triggered rather than consistent, indicates minimal political good will towards prioritising constitutional implementation of the right to health.

b. Political Implementation through Ministries

The executive mainly works through ministries. At the forefront of the right to health, is the Ministry of Health (MoH) mandated to develop and review health policy, supervise the sector activities, dialogue with development partners, mobilise resources and advise other ministries and public agencies on health-related issues (MoH, 2014). Indeed, the MoH has formulated various policies and implemented related programs independently and in collaboration with the international community as envisaged under the laws. Key examples include the First and Second National Health Policy (NHP II) informed by the constitution. Another policy document is the Health Sector Strategic Plan (HSSP) which guides a sector-wide approach (SWAP) for development and delivery of health care. It replaced the project-based model as the focus switched from individual projects to implementation of a coordinated sector-wide strategy.

The initial NHP and HSSP (2000/01-2004/05) highlighted several structural and operational setbacks in government's fulfilment of its constitutional duty to deliver healthcare. For instance, the 2001 Uganda Demographic Health Survey (UDHS) reported poor health indicators such as an increased infant mortality rate from 81 to 88 per 1,000 live births over the five years (UBOS and ORC Macro, 2001). Several factors contributed to these failures including underfunding; inefficient utilisation of the limited Ministry resources; high overhead costs for donor projects, with focus for investment goods rather than efficient provision of basic healthcare facilities; and the failure of patient charges to raise the expected revenues to sustain the health system (Yates et al, 2006). Consequently, the user charges became a significant barrier to equitable budget allocation to basic health care facilities in rural areas and access of medical care for poor people. Other patients resorted to either self-treatment or attending alternative commercial health service providers, a trend reflected in low levels of utilisation for out-patient services both in government and private-not-for profit (PNFP) health units (Yates et al., 2006). This is a demonstrated failure in the political implementation of the right to health, since the majority of the population still struggled to access affordable and quality health care.

In response, the government initiated radical health sector reforms that included SWAPs which encouraged development partners to align support to the government- led strategy to provide budget support rather than project funding; abolish user fees in public hospitals so as to trigger demand, improve management systems, especially financing and supply of medicines; create and encourage public-private partnerships; decentralize service delivery by capacity building at

district level; and improve resource allocations especially to district primary health care services. Equally, the HSSP blueprint focused on reducing morbidity and mortality from ill health and advocated for delivering a Uganda National Minimum Health Care Package (UNMHCP) in an efficient and equitable way, targeting poor and disadvantaged people in line with the principles of the Poverty Eradication Action Plan (PEAP). The UNMHCP approach is both curative and preventive with services ranging from the control of communicable diseases, integrated management of childhood illnesses and immunisation, health promotion and education and maternal health services (Yates et al., 2006).

A second ministry relevant to health is the Ministry of Gender, Labour and Social Development (MGLSD) charged with promoting cultural growth, gender equality, development of labour productivity, social protection and community transformation. It is also mandated to empower communities to access, participate in, manage and demand accountability in public and community based initiatives. The Ministry is also mandated to protect vulnerable persons from deprivation and livelihood risks (MGLSD, 2018). Despite their extensive mandate to contribute to equal access to all public services including health for women and children, the study found scattered evidence of the MGLSD making deliberate efforts towards programs eliminating sexual gender based sexual violence and support community rehabilitation for the disabled. Moreover there was hardly any indication of close collaboration with the ministry of health on the health aspects of their initiative.

The third body is Ministry of Education and Sports (MoES) which is tasked to provide technical support, coordinate, regulate and promote quality education and sports to all Ugandans for national integration, development and individual advancement. Accordingly, the MoES ought to promote mass sensitisation about the right to health, maternal health, contraceptives and menstrual hygiene and sex education, among others. The study found that MoES has various initiatives such as incorporation of health in the curriculum at all levels from elementary to tertiary institutions, alongside the HIV Workplace Policy.

The Ministry of Finance, Planning and Economic Development (MoFPED) is mandated to develop and monitor appropriate policies and strategies that guide national expenditure and review and appraise programs in liaison with other public bodies (MoFPED, 2018). It is responsible for ensuring prioritised allocation of sufficient funds for health in the annual budget and their transparent usage and accountability. However, the study found that year on year, the health sector is allocated less funds than it requires and thus most of its systems remain underfunded by the government or resort to dependency on aid from external funders (Colenbrander et al., 2015). For example, the doctors' industrial action commenced primarily on grounds of poor remuneration, lack of satisfactory working conditions and lack of adequate drugs and other medical supplies (Okiror, 2017). Such funding shortages illustrate low political will to implement the constitutional right to health.

Lastly, there is the Ministry of Local Government (MoLG) which supervises compliance of the local governments with their statutory obligations, national policies and standards, as well as ensuring that they are transparent and accountable in the use of public resources (Government of Uganda, 2015). Section 3 of the Local Governments Act establishes the district as a unit of the local government, Section 9 makes a council the highest political authority within an area of jurisdiction of the local government, and Section 10 provides for the composition of district councils to include the chairperson, 33% women councillors and two councillors with disabilities, one of whom must be female (Republic of Uganda, 1997b). Section 23 provides for the lower local government councils at the sub county council. Section 47 also provides for county chairpersons, parish and village executive committees with several secretaries for portfolios such as security, finance, and women affairs.

c. Decentralisation in health service delivery

The political implementation of the right to health is also done through local government structures. Specifically, the Ugandan health service delivery system is spread out across the

country and provides services every day. It is important to understand the organisation of this level of implementation as it is often the first line that interacts with Ugandan citizens when they are in immediate need of care. The Government of Uganda (GoU) decentralised its health system as a way of empowering its citizens to participate in the process of development and improve their livelihood in critical sectors such as health. This decentralisation of health services created two levels of health sector administration, one at the central government and the second as local government. The latter provide health care through a referral structure. At the grassroots levels are the Village Health Teams (VHT) also known as Community Medicine Distributors. These are supposed to be in every village to give patients basic advice and refer them to health centres. The next level is Health Centre IIs, which according to the Government Health Policy are supposed to be in every parish. However, this is largely not the case. For example, it is only Ojom parish, out of the 6 parishes in Katine sub-county, that had a Health Centre II by 2009 (Kavuma, 2009). Referrals from Health Centre IIs are sent to Health Centre IIIs, which are meant to be in every sub-county, while Health Centre IVs serve counties. Health Centre IVs are mini hospitals which should have the capacity to admit patients and conduct surgery under the care of senior medical officers. However, many of them are non-functional units due to the lack of beds, water and electricity.

Even then, through the process of political and administrative devolution of power in Uganda, local health personnel have assumed greater responsibility and control over the medicines budget (Article 176 of the Constitution of Uganda). This provided the necessary background for an accelerated transition to an integrated 'pull system' of medicines supplies that is more responsive to locally determined demand and the changing requirements of a dynamic health system. However, there are often medicine stock-outs at some health units and a growing reliance on new and more expensive medicines that are often funded through global initiatives with vertical programming and parallel funding structures. Stock-outs become a huge challenge, especially when 50-90% of medicines are paid for by the patients themselves already (Nazerali et al., 2006). This has stringent implications for the pull system marked with an inadequate capacity for inventory management in districts where staff is not equipped with the necessary skills for executing this duty.

There is also a marked failure to appropriately plan for budget spending in some districts that are especially hard to reach. This is majorly attributed to late disbursement of funds by the MoFPED leading to a difficulty in spending money within a few remaining months of the financial year. Rural districts equally have inadequate capacity to spend. This is partly due to their limited power to attract good human resources despite the adverts they publish throughout the financial year. This leaves them with no option other than to annually return huge sums of money to the consolidated fund because they lack capacity to spend (Nazerali et al., 2006).

Despite the commitment to decentralisation, local governments have limited financial autonomy and their activities continue to be primarily financed by the central government, which in turn retains significant control over the local administration of health services. One solution to that problem was the cost-sharing scheme in which central government part paid medical bills and the rest was met by the patient. However, government scrapped it due to limited funds (Burnham et al, 2004). Despite heavy lobbying for its reinstatement, it would be important to examine if the reinstatement would absolve the state of its full-fledged duty to provide basic health care to its citizens.

Nazerali et al., (2006) identify four additional obstacles to the health sector needs to deal with, which are: unfair financing for health including medicines, high medicines prices, unreliable delivery systems, and irrational use of medicines. Budget and expenditure cuts associated with implementation of macroeconomic stabilisation and adjustment programs lead to shortages of medicines and deteriorating facilities. Demoralized, poorly paid health workers charge patients under-the-table fees, divert medicines, practice privately during working hours and become increasingly uncaring towards patients. The lack of financial skill-sets in decentralized settings leads to poorly administered budgets with little relation to the health needs of a community.

The above discussion indicates that the government is yet to realise the minimum standard required to dispense its obligation to provide health services to the people of Uganda. Although it has comprehensively documented its commitments via policies and strategies at different levels and ministries, the formal written undertakings have not persuasively translated into better health for all Ugandans. Instead, it is clear that the government engages in several duplicitous programs, scattered across different ministries with minimal coordination of them all, towards a common objective. As a result, it is still difficult to consolidate the gains made in achieving the right to health, and the budgets are spread thin, resulting into less equitable allocation of funds to avail sufficient and quality health services in the remote areas.

4.2 Judicial implementation

The judiciary's actions are a determining factor of the constitutional implementation of the right to health. Article 126 of the Constitution confers judicial power on the Ugandan courts of law and states that it is to be exercised in conformity with the law, values and norms of the people of Uganda. Pursuant to Article 128 of the Constitution, the judiciary must be independent and act freely from any influence of any other individual or entity. Twinomugisha (2015) warns that the constitutional right to health is illusory if its enforcement is not possible. For the realisation of the right to health, it is essential that the judiciary apply and widely interpret the collection of constitutional rights that embody the right to health. The courts have a great power in the administration of justice in cases where citizens seek redress for the violation of the rights that embody the right to health. We thus analyse the implementation of the right to health by the judiciary, which serves to determine whether the courts have enabled or disabled access to affordable quality health care services in Uganda. This assessment will also further inform Ugandan litigators about how the Courts have reacted in such cases and how they can effectively design future litigation strategies on the topic.

Article 129 of the Ugandan Constitution establishes the hierarchy of Ugandan courts. The Supreme Court is the highest and final appellate court, implying that its decision is final. Subordinate to the Supreme Court is the Court of Appeal and the Constitutional Court. The former handles appeals and the latter determines matters of constitutional interpretation in virtue of Article 137 of the Constitution. Subordinate to both these courts is the High Court where cases are heard by High Court Judges. It is divided in several divisions, including the Commercial division, the Land division and Anti-Corruption division. Some cases regarding crimes are qualified as capital offences (e.g., murder, rape, aggravated defilement) are heard before the High Court without going through a trial at the subordinate court, the Chief Magistrates Court, whose mandate does not cover such offences (Article 139 of the Constitution) (Republic of Uganda, 1995a).

a. The Supreme Court's role in enforcing the right to health

The Supreme Court has had few opportunities to intervene in the enforcement of health rights and has produced mixed judgments on the topic (In the case of *Charles Onyango-Obbo & Another v Attorney General*) (Uganda Constitutional Court, 2014). When presented with the opportunity to pronounce itself on matters of health, the Supreme Court has often referred to legal and hierarchy issues to send the cases back to the lower courts and refrain from expressing itself clearly on the topic. Therefore, as it will be demonstrated from case law below, the Supreme Court's contribution has been mostly of a procedural mediator in nature rather than beneficial to the substantive advancement of the right to health.

An important recent addition to the Ugandan jurisprudence on the protection of maternal health and the power of the judiciary from the Supreme Court is **CEHURD & 3 Others v Attorney General** as in Supreme Court Appeal No.1, 2013 out of Constitutional Petition No.16 of 2011 [2012]; UGCC 4, 2012) (Uganda Supreme Court, 2012). In this case, families of two women who died during childbirth and CEHURD claimed that the government failed to provide maternal health services in governmental hospitals and health facilities, and thus violated the right to health under Objectives XIV (b) XX, XV and Article 8A of the Ugandan Constitution, the right to

life under Article 22, the rights of women under article 33, and the rights of children under Article 34. The Constitutional Court dismissed CEHURD's petition on the grounds that it did not raise competent questions that required Constitutional interpretation and that the issues brought up by the petitioners could not be examined due to the Political Question Doctrine. CEHURD appealed the decision, arguing that the Constitutional Court erred in law in applying the Political Question Doctrine; in stating that the questions did not require constitutional interpretation under Article No.137; and in determining that the petition required them to review and implement health policies.

The Supreme Court sent the case back to the Constitutional Court to be heard again with new considerations. The Court held that Article 137(1) vests powers of interpretation of the Constitution in the Constitutional Court, and that Article No.137(3)(b) of the Constitution gives a right to any person who alleges that an act or omission of an authority is inconsistent with the Constitution to file a petition with the Constitutional Court to seek redress. It was thus concluded that the Political Question Doctrine has limited applicability under Uganda's current constitutional order and that the Constitutional Court erred in striking out the appellant's petition on the ground that there were no competent questions. Justice Kisakye explained that the interpretation of the Constitution is essential to public health, and that it is hence in the interest of justice that where an act may be unconstitutional, Article No.137 allow for the entertainment of a petition making such a claim. The Court's decision can be perceived as reticence to intervene on substantial matters to promote the respect and protection of health rights, since it offered a procedural remedy by sending it back to the Constitutional Court. It can also be qualified as a disappointing outcome since sending it back for review creates important delays in the implementation of the right to health. One could also argue that this decision contradicts the principle established in Article 126(2)(e) of the Constitution, which states that court ought to administer justice without undue regard for technicalities. In such cases, the court must then perform a difficult balancing act between the role of structural hierarchies and procedure, and the interests of the administration of justice in the urgent health cases overtaking Uganda.

On the other hand, CEHURD & 3 Others v AG sets valuable precedent for advocates of the right to health. By holding that the Political Question Doctrine has limited applicability in Uganda, the Supreme Court emphasized that governmental policy, acts, and omissions in the delivery of health care services and other sectors are subject to judicial review to ensure their constitutionality. In doing so, the Court protected access to justice and took a step in recognizing the enforceability of the right to health and other socio-economic rights. This decision is also in line with CEHURD's appeal, which was largely based on the claim that the Constitutional Court's error in dismissing the petition. The case did not allow for the Supreme Court to provide clear substantive material on the maternal health treatment that should be given, but does restore confidence to litigators who had been discouraged by the precedent set by the Constitutional Court.

b. The Court of Appeal and the Constitutional Court's role in the enforcement of the right to health

In contrast to the Supreme Court, both the Court of Appeal and the Constitutional Court have entertained a significant amount of cases on maternal health and the broader right to health. Below is the examination of important recent cases from these courts on the advancement of the right to health.

The right to health has often been undermined due to procedural matters and judicial restrictions, as illustrated by the Supreme Court judgement mentioned in the previous section. The judgment made by the Constitutional Court in the case of Ismail Serugo v Kampala City Council & Another clarified the restrictive mandate of the Constitutional Court and affirmed that it consisted only to hear matters squarely in the ambit of Article No.137 and not to determine matters to do with the enforcement of rights under Article 50 (Constitutional Appeal No.1 of 1998) (Uganda Supreme Court, 1999). Technicalities have been obstacles to the enforcement of the right to health in several recent cases, including in the case of Joyce Nakacwa v A.G (Constitutional Petition No.2

of 2001) decided by the Constitutional Court of Kampala (Uganda Constitutional Court, 2001). Nakacwa delivered a baby girl on a roadside and proceeded to the Naguru Kampala City Council Clinic with the baby still attached to her. At the clinic, Nakacwa was referred to Mulago Hospital without a proof of referral and was forced to walk outside and sit outside with her baby while being dizzy from losing blood. She was later accused of stealing the baby and was subjected to a vaginal inspection with polythene bags. She was arrested and detained for 45 days without a trial and was stopped from breastfeeding. The baby died at Sanyu Babies Home. In its decision, the Constitutional Court dealt with preliminary objections brought up by the respondents, but did not address the allegations and substantive questions raised by the petition itself. The relevant objection to this discussion is the respondent's claim that the petition was time barred because it was not submitted within thirty days of the petitioner's release from custody. The Court held that each decision about the application of the time limitation rule must be confined to its own peculiar facts. In this case, the petition was not time barred because the 30-day period began after the petitioner learned about her child's death.

In the case of *Uganda Association of Women Lawyers & 5 Others v Attorney General*, the court goes further in ruling that the thirty days began to run from the day the petitioner perceives the breach of the constitution and that each decision ought to be made in the spirit of the words of Supreme Court Justice Mulenga: "to make the rule workable and encourage, rather than constrain, the culture of constitutionalism" (Constitutional Petition No.2 of 2002) (Uganda Constitutional Court, 2002). . Litigators can thus enforce human rights during a more flexible period of time depending on the special circumstances of the case brought before the court.

In the case of *Law and Advocacy for Women in Uganda (LAWU) v Attorney General*, (Constitutional Petition No.8 of 2007) the Court held that female genital mutilation which is strongly practised among the Sabiny, Sebei and Pokot tribes, violated women's rights enshrined by Article 33 of the Constitution, as well as their right to life and freedom from torture (Uganda Constitutional Court, 2010).

In *CEHURD v Attorney General* (Constitutional Petition No.16 of 2011) the Constitutional Court got a golden opportunity to determine whether the state was obliged to provide basic health care for women (Uganda Constitutional Court, 2012). The facts arose from government's repeated failure to facilitate safe child delivery, and sought constitutional interpretation as to state obligations in fulfilling women's rights. Similar to the legalistic evasion manifested by the Supreme Court above, the Constitutional Court initially refused to determine the case on its merits. Instead it exonerated itself from enabling constitutional implementation on grounds that the issues for determination were political questions outside its mandate, and dismissed the petition. This petition arose out of the state's failure to provide basic health maternal supplies in government health centres and the imprudent and unethical behaviour of health workers toward expectant mothers, which the petitioners claimed was inconsistent with the Constitution. Initially the Constitutional Court held that their role, as stated in Article 137, is to interpret provisions of the Constitution, and tasked the petitioners to prove before court that the constitutional provisions had been violated. The petitioners had not raised the question of constitutional interpretation and despite the notoriety of the challenges of public health services in Uganda, the Constitutional Court was reluctant to hear the petition because of the Political Question Doctrine.

They instead shifted the implementation burden from the judiciary and noted that the Executive has the political and legal responsibility to determine, formulate and implement policies for the good governance of Uganda. They focused on the administrative preserve of the Executive and denied that the court could intervene, holding that if this Court determines the issues in the petition, the judiciary would be substituting executive mandate with its own discretion. As a result, the Constitutional Court dismissed the petition and thereby absconded from its duty to enforce health justice for pregnant women. The case demonstrated the low judicial enthusiasm to creatively enforce the right to health in Uganda, with preference given to claims of jurisdictional and hierarchical limitations of a particular court.

Another illustration of judicial reluctance and bureaucracy as a deterrent to implementation of the right to health by the Constitutional Court is *Uganda Network on Toxic Free Malaria Control Limited v Attorney General* (Constitutional Petition No.14 of 2009) (Uganda Constitutional Court, 2009a). The Court dismissed the petition for being brought by the wrong procedure, because the petition was brought under Articles 50 and 137 of the Constitution and was contending that government's action of spraying DDT in Oyam and Apac districts to control malaria was contrary to Articles 20 and 39 of the constitution. The Court dismissed the petition because the petition had no component of constitutional interpretation to it. A court sensitive to health justice should have recognized the violation, stayed the action of spraying and referred the matter to an appropriate court for redress. Their failure to recognize the violation on account of wrong procedure hindered the right to health via a clean and healthy environment. According to the Court, the parties should have sued under Article 50 which provides for redress from the high court when the right to health is threatened or contravened.

c. The High Court's role in the enforcement of the right to health

Article 50 of the Constitution gives the High Court unlimited original jurisdiction over all matters including the enforcement of rights. Indeed, the study found that the High Court compared to its superior courts has significantly succeeded in the advancement of maternal health care. The High Court's position has been clear and not evasive as seen in several of its decisions.

At the minimum, the state is obliged to provide basic medical services as per Objective XX of the Constitution. In the criminal case of *Uganda v Kyasimire Florence & Another*, (High Court Criminal Session Case 63, 2013) the accused were jointly charged in two counts of embezzlement of assorted medical items belonging to the Isingiro District Local Government (Uganda High Court, 2013a). The first accused was apprehended as she prepared to leave the Health Centre to go to her home in Mbarara. The second accused on the other hand was found with mattresses belonging to the Local Government and some assortment of drugs. The Court held that prosecution had diligently executed their evidential burden and standard of proof and found the accused guilty of embezzlement because the first accused had taken the items into her home, which was not a treatment room and the quantity of items she had taken were voluminous to dispel any intention of carrying out first aid as she had alleged. This case demonstrates the ability of the High Court to render criminal sanctions against people who intend to steal drugs and other maternal health supplies.

This case is progressive in the realisation of the right to health because it reinforces transparency and accountability by health service providers entrusted with public resources. The Constitution in Objective XXVI and Article 164 (2) require that public officers are held accountable in their offices. Transparency and accountability ensure continuous availability of medical supplies and services allocated for a given community. By finding the accused guilty of embezzlement of medical items contrary to the provisions of the Penal Code Act, the court upheld the right to health through ensuring that the availability health services was not curtailed by embezzlement of service providers.

To achieve transparency and accountability in health systems requires regular monitoring. The constitution in Article 189(1) provides for specific duties of government in the sixth schedule, including the duty to establish a Health Service Commission that monitors health systems so as to identify the gaps and risks and take remedial actions. In the case of *CISE Dispensers (U) Limited. v. Executive Secretary, National Drug Authority* (UGCA 38, 2010; Civil Appeal No.20 of 2009) the court upheld the need for monitoring as key to promotion of the right to health. In the case, the Executive Secretary, on July 25, 2008, accompanied by the police, entered CISE Limited premises for inspection and impounded some essential and restricted drugs found there and closed the premises as they were not licensed (Uganda Court of Appeal, 2010). The Court of Appeal held that in line with both Sections 8 and 12 of the National Drug Policy and Authority Act, since restricted drugs were found at the appellant's premises, the respondent was rightly impounded them. By this holding, Court stressed the importance of monitoring health facilities and in particular the drugs they supply. In applying Section 12 of the National Drug Policy and

Authority Act, the court protected people from harmful drugs and thus upheld and respected the right to health through monitoring.

In the case of *CEHURD & Others v Nakaseke District Local Administration* (High Court Civil Suit 111, 2012) the plaintiffs sued on behalf of a woman who died at the defendant's hospital due to lack of emergency obstetric care (Uganda High Court, 2012). It was alleged by the plaintiffs that the deceased had an obstructed labour condition but did not receive the appropriate medical care and attention due to the absence of a doctor assigned to her. The judge visited the hospital in locus to assess the evidence and held that the deceased's right to basic medical care was violated when the government hospital failed to provide a mother with access to emergency obstetric care. The defendant was also found to have breached Article 33(3) of the Constitution because the doctor on duty was absent without explanation to conduct the caesarean operation when needed. As a result of the patient waiting in pain for 8 hours without medical attention, she died due to a ruptured uterus. The state was found to have breached its duty to protect women's rights given their unique status and natural maternal functions in society.

The obligation to provide health care extends beyond merely administering treatment but to also providing adequate and accurate information about the treatment of a patient. In the case of *CEHURD & 2 Others v Attorney General and Executive Director of Mulago Hospital* (HCCS No.212 of 2013) a mother gave birth to twins but was given only one baby after delivery with allegations that the second baby was dead (Uganda High Court, 2013b). After rejecting the allegations, she was given the dead body of another baby which DNA tests found were not compatible with her for parentage. The High Court held that failure of Mulago Hospital to inform a mother about the whereabouts of her new-born baby was cruel, degrading and inhuman as it violated her right to access her child's information. The court also directed the Hospital to strengthen measures for protection of new-born babies and also account for the whereabouts of the second baby who was missing. Lady Justice Mugambe granted structural interdicts against the hospital, inter alia, to report back to the plaintiff on steps taken to reduce baby theft at the hospital. This was only the second time in the jurisprudence of Uganda that structural interdicts were granted and the first in the area of the right to health. The decision is celebrated globally and culminated in awarding of the Lady Justice with the Women's Link International People's Choice Gavel Award.

Another illustration of the intersection of health and the right to access information, as provided in Article 41 of the Constitution, is Paragraph 12 of General Comment 14 on the right to the highest attainable standard of health by the Committee on Economic Social and Cultural Rights, which states that that information accessibility includes the right to seek, receive and impart information and ideas on health. It was applied in the case of *Greenwatch (U) Limited Vs Attorney General & Another* (High Court Miscellaneous Cause 139, 2001) (Uganda High Court, 2002). The facts of the case are that Greenwatch Limited, an environmental advocacy NGO, requested a copy of the Power Purchase Agreement executed by AES Niles Power Limited (AESNP) and Uganda Electricity Board (UEB) establishing a commercial monopoly over the sale of electricity in Uganda. The government denied the request, stating that the Power Purchase Agreement contained technical and commercial secrets and could not be availed due to confidentiality and the need to protect intellectual property. Greenwatch argued that this was a violation of the right to access information under Article 41.

The Court held that Article 41 was applicable to the information in possession of the state, and not only documents signed by it, and that, because of the secrecy of the agreements in question, Greenwatch should have handed in a prior request to the Uganda Electricity Transmission Company. The ruling that Greenwatch was not entitled to access the Agreement on mere technicalities violated the right to access information which, when availed, would have promoted the right to a clean and health environment and in turn facilitated the right to health.

The court in the case of *The Environmental Action Network Limited (TEAN) Versus Attorney General and NEMA* granted redress to the applicants when the right to a clean and healthy

environment was violated (Uganda High Court, 2001). TEAN, on behalf of itself and non-smokers, sued the government seeking protection from smoking in public places. TEAN contended that measures were required to control smoking in public areas, both for the general good of public health in Uganda and to enforce the right to a clean and health environment. The government raised objections, claiming that the application was based on hearsay and that, since TEAN had filed the case, they had no time for investigation. The court overruled the objections and held that when people's rights are infringed, the state is obliged to investigate and intervene before actual damage is done. The court ordered that justice for the applicants should not be denied on account of government abscondment, and upheld the right to the highest attainable standard of health by handling the application competently and recognizing the urgency of protecting the environment and thereby the right to health.

In the case of *Law and Advocacy for Women in Uganda v Attorney General*, the court protected and promoted the right to health of women by dissolving the culture which violated their right to health (Uganda Constitutional Court, 2010). The background of the case is that the petition was brought under Article 137, challenging the constitutionality of the female genital mutilation practice among the Sebei, Pokot and the Tepeth. The petitioner contended that the practice violated Articles 2, 22, 24, 27 and 33 of the constitution. The petition was supported by affidavits and publications all of which showed the painful process and scathing effects of the practice. The Attorney General did not object or respond to the grounds that were raised. The Court declared female genital mutilation unconstitutional because it violates the provisions of the Constitution. The recognition of the court that the right to health includes the freedom from harmful cultures such as female genital mutilation promoted the right to health. The court also guaranteed gender equality, an essential determinant of the right to health.

d. The role of Magisterial Courts

Magisterial Courts were created under the Magistrates Courts Act and make up the lowest level of the Ugandan court system. They handle both criminal and civil matters, as per Section 42 and 207 of the Act respectively. They are ranked in descending order from the Chief Magistrate to Magistrate Grade 1-3, each with different subject matter jurisdiction. Magisterial Courts are the most accessible courts in which citizens can obtain redress, mostly due to their geographical proximity to a given community. However, they are often avoided due to the low ceiling on the quantum of damages awardable. The High Courts are increasingly sought out, especially in cases related to health matters, since the Magistrates Courts are not as respected by the executive. For example, the Kapchorwa Chief Magistrates Court convicted a total of five people from two separate cases for practicing female genital mutilation, but they were then pardoned by the president in 2015 (CEHURD and PATH Uganda, 2015). Overall, the executive's ease in interfering in the judiciary's decision can seem particularly alarming and should be considered as an area of concern by litigators seeking the implementation of the right to health.

Challenges to judicial implementation

Based on the foregoing analysis, this study suggests that the judiciary encounters both internal and external limitations in its implementation of the right to health in Uganda. Internally, many judicial officers are generally unenthusiastic about enforcing the right to health due to higher regard for the procedural black letter law, rather than using the law as a tool for social transformation. Consequently, they prefer form over substance and fail to assert their constitutional discretion to promote and protect the right to health. In essence, the courts subject the right to health to their personal professional performance by relying on procedural technicalities to defer or shift the duty of judicial implementation to lower or superior courts.

Arguably, judges, like many lawyers and civil society actors, may lack an understanding of human rights doctrine. This may be a barrier to framing health rights violations within international human rights law and to litigating issues on health rights, including the right to health in Africa (O'Connell, 2014). This may partly explain why there is scanty jurisprudence on the right to health before 2005, a decade after the constitution came in to force, and testifies to the limited progress made in the judicial implementation of the right to maternal health.

If the right to health was constitutionally recognized, courts could not hinder progressive implementation of the right to health by utilizing judicial discretion to deny the right to health. From the judgments analysed, the study found that the courts enjoy wide discretion to deny or grant the right to health. As a result, the courts have not been able to develop universally accepted jurisprudence on the right to health in Uganda. The constitutional position interpretations are diverse, in some cases, perhaps because of the infancy of strategic public interest litigation on the right to health. In other cases, it is outright judicial avoidance to deal with the right to health as a grey but evolving area. This gap is an opportunity for further study into what factors influence the different courts to determine health cases in a particular jurisprudential direction.

Finally, some of the remedies availed by the courts are difficult to execute, and may ultimately be rendered moot or unhelpful for the litigants. A case in point is the CEHURD v Mulago National Referral Hospital Case, in which the court granted structural interdicts against the respondent hospital. The courts mandated systematic changes to the hospital to ensure this hospital enhance protection and safety of babies, dead or alive, and ordered that these changes be accounted for in a report. The part of the order that is difficult to implement is that the report must be collected and reviewed by CEHURD. This is a positive step in creating accountability and follow-up for changes requested, but it can be questioned why this mandate was given to CEHURD when the delivery of health services is a clear governmental mandate. CEHURD's capabilities to fulfil the requirements provided by the court are not in question here, but rather the court's unofficial acknowledgment that the government is no longer the actor overlooking its own mechanisms. The question is, therefore, how viable it is to execute such relief, and if so enforced, how it realises retribution for the aggrieved person. This is particularly challenging because in health matters, time is of the essence and any delays in the health justice system can lead to loss of lives, money and significance of the relief awarded, especially in cases where the aggrieved dies or becomes incapacitated by poor health.

4.3 Popular implementation

The Constitution of Uganda's Preamble begins with "We the People of Uganda" and highlights the people's ownership of the Constitution. It is meant to signal that the document is the people's creation and should be used to their benefit. Kramer (2004) qualifies the idea that a constitution belongs centrally to the people and that its meaning and enforcement rests on the people as "Popular Constitutionalism" (Alexander and Solum, 2005). Exercising popular constitutionalism is less of a legal, conservative or formal approach, and much more of a citizen-centric approach. It embraces a liberal understanding of the constitutional guarantees and uses them as such to enable societal change. It involves civic organisations, social movements, and private sector players, including the media, in holding the government accountable in fulfilling its duties.

Several stakeholders participate in implementing the constitution in order to hold individuals, agencies, and governments accountable to the duties and obligations it imposes on them. As previously discussed, these obligations arise from Article No.20(2) of the Constitution, which imposes a duty on all government agencies and individuals to respect, promote, and uphold every human right, evidently including those related to health. These duties are meant to be facilitated by Article No.21(4), which guarantees that no discrimination provision can prevent Parliament from drafting policies and programmes that aim to redress any inequality in society or which is demonstrably justified in a free and democratic society. An increasing number of popular initiatives are born to enforce these obligations, advance the realisation of the right to health and cure social, political, economic, and cultural ills within Ugandan society. For example, in the fight against deficits in the health system, local medical workers took action and demanded for better wages, working conditions and medical supplies for their patients (Okiror, 2017).

Such initiatives should be encouraged as they indicate that citizens are aware of their constitutional rights and are involved in the betterment of their society. Considering the rise in public action, it is crucial to examine how popular constitutionalism works and what potential it has to advance the realisation of the right to health. It is currently spearheaded by CSOs,

movements, and individuals demanding for better health care. Below are recent examples of popular initiatives in Uganda.

a. The Black Monday Campaign

In an effort to fight corruption in Uganda, activists launched a campaign in November 2012 called the Black Monday Campaign (as accessed from authors experience and from ngoforum.or.ug). It evolved organically amongst citizens frustrated by the government's inability to eliminate corruption in their country. The campaign was not informed by a formal strategy but rather from a shared conviction amongst citizens seeking to stage spontaneous actions to expose bribery with the hope to deter future corruption schemes.

CSOs joined the movement and organised a week of mourning as a symbol of patriotism and shared grief with the victims of corruption who had lost their loved ones. Authorities such as the Uganda Law Society and development partners like Action Aid and the NGO Forum followed with activities such as the launch of a citizen prison, social media activism, press conferences and street demonstrations. For over five years, the Black Monday Campaign has mobilized individuals and organisations to denounce the misappropriation of public funds. It can unfortunately not be said that the campaign led to the elimination of corruption in Uganda, but it did succeed in increasing media support for CSOs in the fight for transparency and accountability. It also increased the cohesion between CSOs and sensitized the population on the harm done by the unchecked abuse of recourses on human rights.

On the other hand, the campaign was severely silenced by the government, who blocked several campaign initiatives, arrested activities and threatened others to deter further requests for transparency and accountability. Therefore, an important take away from this campaign is that there is a need for a system that will support citizens in protecting themselves when they are involved in activism and are faced with government intimidation, threats, and prosecution.

b. A peaceful demonstration for justice for maternal deaths

Uganda is one of the countries that failed to meet the commitment it made under MDG5 to improve maternal health. The maternal mortality rate remained at over 438/100,000 women dying annually, unacceptably high and far above Uganda's target 131/100,000 women dying annually by 2015. Even in 2017, two years after the MDG deadline, the maternal mortality rate was only reduced to 336/100,000 (UBOS and ICF, 2017).

In March 2011, CEHURD filed Constitutional Petition No.16 to challenge the state's failure to provide basic maternal health commodities to expectant mothers, which was causing their death in government health facilities. Several other CSOs rallied under a coalition to stop maternal mortality in Uganda to support the Petition in Court and advocated for an improved health budget, increased salaries for health workers, and better worker retention and recruitment. Unfortunately, the court sessions did not proceed as hoped despite the important pressure from the public. On several occasions, court sessions did not begin on schedule because either the Attorney General or the judges were not present. When the case was finally reviewed, the state raised a preliminary objection blocking the court session from proceeding on grounds that the Petition addressed issues outside of the Judiciary's mandate and of a rather political nature. The Court then opted to give their ruling on notice, but several months later, despite an extensive follow-up process from lawyers, the court did not deliver a judgment (Yamin, 2013).

As a response, the CSO coalition organized a peaceful demonstration. The event was also topical because the government had just announced that an important portion of government funding would be allocated to buying new fighter jets. The CSO activists marched from Kamwokya, a suburb of Kampala, to the Constitutional Court to express their concern over the judgment's seven-month delay. An expecting mother led the demonstration and presented the issues to the registrar, accompanied by a band and policemen. The main argument made was that the judiciary's delay in pronouncing itself on the Petition meant that preventable maternal

deaths continued to occur unchecked, and that a prompter response by the Court could have stopped many of them.

Following the demonstration, the judiciary sent an apology to the CSOs and the general public, and delivered a favourable judgment two week afterwards (Wesaka, 2012). The CSOs efforts helped to build empowered communities, aware of their constitutional rights such as freedom of speech and their right to peaceful assembly. Furthermore, it highlighted a need for more elaborate citizen mobilisations and collaborations as population actions for the implementation of the constitution. Finally, it exposed gaps in the current laws and public institutions and proved the effectiveness of civil action in holding the government accountable to its constitutional duty to promote and protect health rights.

c. The walk to work campaign

The walk to work campaign was born in April of 2011 by opposition leaders who formed a group called Activists for Change (A4C). They were concerned about people's discontent with changing conditions, such as increasing fuel, food, and transportation prices, and about the growing frustration over poor social service delivery. The campaign's strategy was to peacefully protest against the government's misappropriation of public funds. Specifically, they brought attention to planned expenditures on eight fighter jets for \$740m and \$1.3m on a presidential ceremony when voters could not afford food or access basic social services (Namiti, 2011).

The peaceful protests took the shape of communities walking to work while protesting the escalated food prices that were increasing inequality and threatening their health. In 2012, the government banned A4C and declared it to be a criminal organisation. Although A4C's association to a political party is an indicator that the group's activism might have been driven by political incentives, the state's reaction to their initiative was considered by many to be brutal and unwarranted, especially when it was known that governmental agents had arrested and tear-gassed participants (Matovu, 2012). Moreover, being part of the opposition and organizing events is lawful in a multiparty. The opposition is fully entitled to hold the state accountable, as are all citizens.

d. The Pads4GirlsUg campaign

Around the world, menstruation is highly stigmatised and considered as a social taboo. This is especially true in Uganda, where the stigma around menstruation limits the enjoyment of daily life for girls during their menstrual cycle and often leads to serious health problems. In March 2017, access to menstrual hygiene supplies and information became the subject of a heated public debate in Uganda. The discussion came up in response to the President's failure to respect his election promise of offering free sanitary pads to female students. A year after his presidential victory, the President's wife, also the Minister of Education and Sports, informed the public that the state lacked the necessary funds to fulfil the election promise. Her statement triggered citizen action that aimed to mobilise the resources necessary to make the delivery of sanitary products and information to girls in underprivileged schools possible.

At the forefront of this effort was a campaign dubbed "Pads4GirlsUg" led by Dr Stella Nyanzi, a human rights activist, researcher and social media influencer. The campaign symbolically kicked off on International Women's Day and, from an individual project, grew into a working group of over 40 citizens who collected funds and menstrual products and distributed them across the country to help girls stay in school. In four months, the campaign served over 18 districts all over the country. However, the project was terminated by the arrest and prosecution of Dr Nyanzi by the state, for reasons unrelated to her specific involvement with the project. The state also prohibited public schools from receiving aid from the campaign, leaving private schools as the main benefactors, and supported the actions of security forces that arrested citizens participating in the campaign (Akumu, 2017)

Although the formal campaign ended due to the issue above, it continued on social media, creating awareness about the stigma surrounding menstruation. As such, it helped to reduce

inequalities in access to menstrual hygiene supplies, and reduced absenteeism amongst young girls who were provided with both reusable (good for one year) and disposable products. Moreover, the campaign sensitized the beneficiaries about sexual and reproductive health and provided information to young girls about how to use menstrual hygiene products in a way to limit sepsis and other illnesses often caused by the use of unsafe menstrual materials (e.g., contaminated with sand, banana fibres or sisal). Overall, the campaign was a short and impactful story of the citizen action driven by social media and crowd funding advancing the right to health. It also demonstrates the intersection between several human rights, such as equality, education, access to information and freedom from degrading conditions. It confirms that the right to education is a powerful enabler to the right to health, and vice versa. In addition, it provided lessons and inspiration to civil actions considering their own participation in the advancement of the right to health and exposed the state's failure to fulfil its obligations. Finally, the campaign brought up several questions on what justifies a government's refusal to provide menstrual hygiene products as a basic health supply for female students, and what measures can be taken to compel the Ministry of Health and of Education and Sports to provide them. Unfortunately, as seen above, such individual efforts may not be sustainable.

e. Industrial action by doctors and medical interns

The medical personnel in public health facilities have gone on countless lawful labour strikes demanding better salaries, working, and living conditions, and a sufficient supply of medical supplies for their patients. The most recent strike took place in November 2017, when several doctors across the country went off duty for a fortnight. During the strike, the umbrella body Uganda Medical Association (UMA), under the leadership of Dr Obuku Ekwaro, sought to engage in a peaceful dialogue with government officials to reach an agreement on fair and adequate terms of employment for doctors and interns (Okiror 2017).

A number of public health facilities rely on medical interns to treat patients due to the shortages in medical staff. Regardless, the government insists on implementing degrading policies for interns, and on giving them small allowances that they often only receive after significant delays. The government introduced a policy that would restrict government sponsorships to medical students that complete their internship placement in hospitals. Medical interns in private clinics went on strike to contest the initiative. The government also proposed that government sponsored interns would be obliged to complete two extra years in their internship placement before being able to obtain their practicing licenses. The interns went on strike again to contest this policy, which severely affected the operations of health facilities that heavily relied on these students (Namagembe, 2017).

The government responded to these strikes by threatening to dismiss all the public doctors and interns on strike. It also attempted to sue the association of public doctors challenging the legality of their organisation and their right to industrial action guaranteed by Article 40 of the Constitution (Okiror 2017). The government also sent military doctors to hospitals to fill the gaps created by the strikes, but they were few and considerably less qualified. Hence, the government's response to strikes has proven itself to be unproductive and has failed to lead to any progress in the delivery of health care to Ugandans. The government's indifference towards the wellbeing of Ugandan medical workers is harmful to the workers' right to health, and also to citizens' right to health as their care is largely determined by the medical workers and the health supplies they advocate for.

Summary

The examples above demonstrate that popular constitutional implementation in the form of civil activism is on the rise in Uganda. It has been most successful in creating national discussions on government spending and in empowering individuals to keep their government accountable on all fronts, especially in their delivery of health services. Popular activism also demonstrates the crucial role of social media in the mobilisation of citizens due to its capacity to bring people from different regions together at a single event. On the other hand, these examples also illustrate that initiatives are sporadic and are not part of a continuous monitoring process of the government's

actions. Moreover, activism is often terminated by the criminal justice system and military violence coordinated by the state. This threatens the sustainability of popular initiatives and reaffirms an uncontested trend of state oppression.

These challenges raise opportunity for further study as to how to enable popular implementation to sustainably engage the state in delivery of affordable and quality health services without fear. Finally, this implementation approach makes a case for further study into the role of social media activism in holding the state accountable for its obligations, and how virtual activism may neutralise the negative effects of harmful government responses to traditional activism.

5. Challenges in implementing the right to health

In spite of the constitutional, legislative and policy frameworks in place allowing for the realisation of the right to health, the right remains elusive for the majority of Ugandans who do not receive proper treatment as indicated by Uganda's alarming mortality statistics cited earlier (Twinomugisha, 2015). It is indeed possible to conclude that the application of the constitutional provisions which pertain to the right to health did not translate into the delivery of efficient health services. Although some progressive initiatives have been taken, in the shape of both legal and popular action, the realisation of the right to health still faces significant challenges. This section identifies these challenges and examines their impact on the well-being of Ugandans.

5.1 Constitutional Limitations

First, it is important to acknowledge that the constitution itself is an obstacle to the realisation of the right to health since the constitutional text does not explicitly provide for it. The presence of the right under the national objectives, rather than under the bill of rights renders its enforceability easily questionably by the judiciary since the state objectives and principles are not automatically justiciable. Working towards changing the constitution for it to provide for the right to health therefore seems like the next logical step in improving health in Uganda, but constitutional amendments require enormous efforts. Consequently efforts to implement the right are laborious because textualist politicians, citizens and judges are sceptical of imputing non-existent entitlements from the constitution. As seen from several court cases above, most judges restrict their interpretation, role and decisions about the constitution to its original language as a reflection of the intention of its draftsmen. A literal construction and application of the current constitution renders the right to health vague and difficult to assert towards better health service delivery.

Changing the Supreme Court's usual originalist stance to one which embraces the constitution as a living tree can require decades of commitment and powerful jurisprudence. A partial solution to this constraint is pragmatism by all rights holders and duty bearers in their construction and application of the constitution. Whereas an express provision would go a long way in holding the government accountable in the fulfilment of their duties, it is advisable to take a comprehensive approach and purposively interpret the bundle of constitutional rights related to health. For instance, advocates involved in strategic interest litigation ought to appeal to the courts to treat the constitution as a living law and a tool of societal transformation, so as to use the Mischief Rule of interpretation to curb threats or cure violations of the right to health. Similarly, it is suggested that civil society action focus on the substance rather than form of the constitution to demand adequate, affordable and quality health services across the country from the state.

5.2 Legislative barriers

As earlier stated, the Parliament is obliged to enact laws for the order and good governance of Uganda. However, to date there is no comprehensive law on the right to health in Uganda. Instead there are scattered laws on a few aspects of health. Some of them preceded the current Constitution going as far back as the colonial era, and have been rendered obsolete and overridden by numerous scientific and technological developments over the years. As cited earlier this includes the Public Health Act of 1935, the Mental Treatment Act from 1938, and the

Venereal Diseases Act, 1977. Fortunately, the Public Health Act is under review, although in a prolonged process.

The public discourse on legal termination of pregnancy has remained controversial despite the increased number of maternal deaths due to unsafe abortion. Article 22(2) of the Constitution prohibits abortions unless authorized by the law but not such law has been made. Tamale (2016) among other scholars and activists have called on the Ugandan government to revisit the legal regime on termination of pregnancy so as to operationalize Article 22(2) of the Constitution and synchronise it with the CEHURD 2015 Policy Guidelines (Tamale, 2016). These guidelines propose amendment of the Penal Code to streamline it with the Constitution by clearly stating the conditions under which women can legally obtain safe abortions services and the doctors can treat them without the risk of prosecution. In addition, there are emerging areas such as surrogate motherhood which require immediate legislation to curb their risks while harnessing their benefits.

5.3 Policy and institutional barriers

Although Uganda has several health policies, many are not respected with limitations in improvements in population health. For example, the Standards and Guidelines for the Reduction of Maternal Mortality and Morbidity Due to Unsafe Abortions, launched in 2015, aimed to reach the goals it had committed to under the Maputo Plan of Action and the SDGs (Mutatina et al., 2017). However, women continue to die daily while conducting clandestine abortions because the Penal Code Act has yet to be amended to decriminalize justified and unsafe abortions and therefore remains inconsistent with the new policy (Mutatina et al., 2017).

Further, the policies are multiple and each with a short-to medium tenure. Their objectives thus may have limited impact, when undertaken for a few years without extension or renewal. Equally the multiplicity of policies without a centralised focal point for their coordination renders the small gains made by each Ministry less effective. It is suggested that the health ministry actively coordinate all health-related efforts amongst the ministries in order to consolidate all the gains towards common policy objectives and implementation.

At the same time, the majority of the institutions with the mandate to uphold, protect and promote the right to health are severely constrained in terms of their financial resources and skilled labour, reducing their effectiveness, the country-wide distribution of their offices and activities as per their mandate. It is typical for institutions to have a head office in Kampala and a few regional offices in major towns or representatives in a few remote areas. This is however not effective as each region has distinct needs. Furthermore, face to face contact is essential in health actions, since it allows for better communication and for a better assessment of the community's needs. Thus, institutions also struggle to effectively enforce the directives given to them by the state regarding the delivery of care. Below are some examples of these institutional limitations.

a. Parliament and the Uganda Law Reform Commission (ULRC)

As reported above, the Parliament has not passed a comprehensive law for the implementation of the right to health. A specific example is its failure to legislate for safe and justifiable abortion, as categorically required by Article 22 of the Constitution. As a result, the statutory regime on abortion in Uganda remains ambiguous and unreliable for women in need of abortion services, as well as their health service providers. To this end, citizens should mobilise and demand that Parliament enacts a bill on lawful abortion at the earliest opportunity and require Parliament and ULRC as a direct duty bearer in legislative reforms, to review all existing laws that impede the enjoyment of the right to health and to align them to the Constitution and international laws applicable. They should then repeal all obsolete laws, amend the insufficient ones as well as draft and pass new laws relevant to health matters. Finally, the Parliament should not stop at making laws, but through the Parliamentary Committee on Human Rights ought to regularly and pragmatically hold accountable the statutory institutions mandated to enforce the laws.

b. *The Judiciary*

The challenges encountered by the judiciary include heavily rigid procedural formalities, strict evidential rules and operational principles such as the separation of power which hampers their expeditious delivery of health justice. On the hand, there are other challenges to the judiciary's implementation to the right to health, which are mostly related to their political ties and knowledge pool. For example, the fact that judges are political appointees makes them prone to interference from the political arena. This relationship is believed to underlie the delayed execution of compensation orders against the state. To safeguard their security of tenure in office, some judges fail to hold the state accountable for its failure to fulfil its obligations to the citizens on the right to health, and thereby perpetrate injustice in the health sector.

The limited number of judicial officers knowledgeable about health laws, policies and practices hinders the judiciary's capacity to deliver judgement addressing the technical and more nuanced aspects of health law cases. Most judges are specialised in commercial or criminal law, of those trained in human rights, only a few major in health rights and there is limited training on health rights in Uganda. As a result, judicial activism towards better health and social justice is still at its beginnings, as demonstrated by the slow approach to adjudicating the right to health discussed earlier. The fact that the Ugandan bench is predominantly composed of men may imply that judgements on maternal health are approached with patriarchal perspectives. This bias slows down progressive decisions in support of better maternity rights.

It is essential for the courts to exercise their discretion in the interest of justice and serve to highlight the gaps in the constitution regarding the right to health and make interpretations of what the gaps mean to realization of the right to health. In this instance, the constitution does not expressly include the right to health, yet health is a natural precondition for, and logical outcome of, the enjoyment of any explicit constitutional rights. When faced with cases of threatened or violated health rights, the Courts can assert their powers without usurping political power, and order the other arms of government to exercise their policy, administrative and legislative mandates towards better delivery of efficient health services to Ugandans. Twinomugisha recommends a bold and creative judiciary, which is prepared to hold the state accountable for failing to meet its obligations over health rights, rather than rely on antiquated doctrines such as the political question, which undermine its constitutional independence (Twinomugisha, 2015).

The courts can also award enforceable remedies beneficial to the litigants including definite timelines for their execution, so that relief is not left subject to the goodwill of rights violators. They should preserve a right to continuously monitor compliance with their orders through an order for the duty bearer to periodically report back to court on their adherence with the judgment, or else face similar action. Civil society and health sector also have roles in this, to engage the judiciary in their stakeholder initiatives to continuously equip them with the necessary tools and information for the promotion of health rights. For example, the Uganda Law Society, Uganda Medical Association and other professional bodies could increase their collaboration and training with the judiciary that relate to the state of health in the country.

c. *Uganda Human Rights Commission (UHRC)*

The UHRC has a mandate under Article No.52(1) of the 1995 Constitution to investigate human rights violations according to its own initiative or upon a complaint from any person or group. It promotes public awareness about human rights and monitors the government's compliance with international human rights agreements. It also recommends Parliament on effective measures to ensure the respect of human rights and orders that compensation be received by victims of human rights violation. However, a review of its work indicates that although the entity receives countless complaints, it does not have an adequate budget or human resources to handle them expeditiously. In addition, when the complaints are dealt with, most of the state actors against whom the orders of compliance are made either delay or entirely ignore the orders, leaving the claimants without compensation (Bakayana, 2006). Hence, while the UHRC's work is essential to the advancement of the right to health, its capacity to create change and redress violations through its surveillance mandate lacks tools for enforcement.

d. *Uganda Police Force*

Articles 211 and 212 of the Constitution establish the Uganda Police Force to protect life and property, preserve law and order as well as prevent and detect crime (Section 4 (1) of the Police Act Cap 303 (Republic of Uganda, 1994). In contrast, the police force is observed to often be violent in its operations, leaving people injured or dead and violating their freedom from torture, cruel, degrading and inhuman treatment. The police is documented to tear gas, shoot live bullets and illegally detain citizens who assemble and mobilise to demand for better service delivery from government (Matovu, 2012; Nakatudde, 2014). An intolerance of demands for accountability and transparency often results in the police dispersing citizen campaigns, and well as blocking them in advance under the Public Order Management Act (Human Rights Watch, 2015). In contrast, the police is often lax about expeditious investigation of violations of the right to health, which delays and impedes access to health justice for aggrieved women and victims injured from gender based violence (ACFODE, 2009).

This includes insensitivity to the sexual and reproductive rights of police women. For instance, in May 2014, four officers were recalled from duty at the Parliament on grounds that they were pregnant, an action contrary to several constitutional guarantees on maternal health. The Police Spokesperson reasoned that this was done because policewomen are expected to wear the uniform with a belt and since they were pregnant and could not wear them, this would compromise the image of the police force (Nakatudde, 2014). Such discriminatory attitudes dehumanise police women and point to attitudes that underlie the harmful handling of pregnant women during arrests without regard to their condition. Similar insensitivities were evidenced in the case of Victor Juliet Mukasa and Yvonne Oyo v Attorney General, where the court found that the examining one of the complainant's genitalia to ascertain her sex amounted to a violation of her right to privacy and freedom from torture as established under the constitution of Uganda (Uganda High Court, 2006).

To curb police brutality and their increased violation of the right to health, the police should be held accountable for their actions by the citizens and judiciary through litigation, complaint recording with the UHRC, and periodic parliamentary summons to report on their performance from a HRBA. They should be involved in citizen organisations as partners and support stakeholders rather than as violators. Such engagements can help sensitize them about their lawful roles and increase cooperation rather than antagonism between all actors.

e. *Academia*

The role of academia in implementing the right to health has mostly been in the form of human rights courses in formal curricula, organizing access to information on health law publications, providing free health and legal clinics to communities and publishing papers on the right to health. However, scholars and academics have a potential to play a much larger role by moving away from a theoretical role and being involved in grassroots information and health programs. The main challenge in this respect is the lack of funding for this and a widening socio-economic divide between academia and the broad population. Academia need to make messages accessible to the general public, including on their own language and participate in improving access to education. This implies adapting to the population's needs and participating in field processes, while also maintaining participation in academia and peer-reviewed journals. This can include holding public dialogues to sensitize people on health rights, on how to assert them, how to hold government accountable, and on how to report violations. Academics can also contribute to monitoring and analysis documents on the state of the health services as well as to strategic interest litigation cases, where they are often recognized to be the voices of experts. A recent example are the nine human rights activists, including Professor J. Oloka Onyango, who applied to appear as friends of the court based on the wealth of information they had accumulated on the state of maternal health in Uganda from their study, publications and teaching (Hassane et al., 2014). The involvement of academics in future cases will inform us on if this act inspired others to follow.

5.4 Political barriers

Uganda is a patriarchal society with family and work frameworks designed by male-dominated power structures. This organisation impedes women's participation in political, familial and societal decision making processes on a variety of topics, including for the better enjoyment of the right to health. In 2015, there were only 28 women with a cabinet position out of the 80 available, and several of them were given state ministers positions, while men occupied full ministerial positions. Studies have found that when women are lacking in leadership positions, governments do not consider gender equality as a priority, gender equality issues are missing from the budgeting process, and women are not present in the financial and peace negotiations (UN, 2016). On the other hand, experts agreed that women's participation in decision making has implications for promoting gender equality (UN, 2005). Thanks in part to women taking up this issue, the eradication of violence against women in both domestic and the public sphere has gained momentum as a global movement (UN, 2005).

This pattern holds true for women's health issues in Uganda. Gender equality issues, especially maternal health care, have not been given the priority they deserved for decades. The dominance of males in cabinet can affect the prioritisation of health initiatives at the policy formulation stage. Health is known to be of a greater concern for women, and since experiences of child bearing are far away from a man's reality, the realisation of the right to health is often of a low priority. The current domination of men in leadership can be identified as an obstacle to the right to health and efforts to achieve gender parity in cabinet should be strongly supported by health advocates.

When President Museveni came to power in 1986, he designed a 10-point programme to restore the country from its tumultuous political and constitutional history. The programme included the improvement of social services such as health care services. The drafting of policies on sexual and reproductive health described earlier represent the presence of a growing interest for women's health. Nevertheless, some of these policies are controversial and end up being withdrawn, as was the case for the policy on access to contraceptives for teenagers and in the continued controversy on policies aimed at increasing access to safe abortion and comprehensive sexuality education discussed earlier. These policies are often not being implemented effectively or elevated to statutes easily enforceable in court. Most health bills remain as drafts for years and the health budget continues to be slim. In this regard, Twinomugisha comments on how resources may be used for regime survival rather than health, as shown in the lack of funds for maternal health care in contrast to high expenditures on purchasing military jets and celebrating electoral victory (Twinomugisha, 2015).

5.5 Economic and service barriers

Uganda's budgetary allocations do not prioritise health funding, with less than 8% of its annual spending is allocated to health (Africa Health Observatory, undated). As a result, hospitals are usually not adequately stocked with medical supplies, they are understaffed, and workers are poorly paid. These issues were a matter of public debate during health practitioners strikes, as previously discussed. For the Ugandan health care system to improve, maternal mortality to decline and the right to health to be realised, one issue is to achieve a greater financial commitment to the health sector and its allocation in relation to health needs.

The World Bank estimates that over half of the Ugandan population lives on less than a dollar a day (World Bank, 2016). The majority can't afford health insurance, but this has not encouraged the governmental to invest in universal health coverage. A National Health Insurance Bill has remained in draft before parliament and not enacted for over 10 years. Poor citizens, largely unemployed or under-employed, do not receive benefits from an employer, cannot afford to pay their medical bills and don't receive care. Many women do not seek professional health services due to cost barriers and opt for as cheaper but often unregulated options such as home remedies or traditional health care (Tashobya et al., 2006). Investment in remote rural and community and primary level health structures is still inadequate, with many health centres lacking clean water, electricity, medicine and basic supplies (Republic of Uganda, 2016). In rural areas, there are few

and far scattered health centres III and IV so women and expectant mothers need to move very long distances to access services, with the health risk this implies. This was illustrated in the case described earlier of Joyce Nakacwa who moved a long distance whilst in labour, arrived at a facility with the baby still attached to her body and was ignored and lost her child. This situation contrasts with services for urban and wealthier women. Further, many urban women earn their own income, can pay their own bills and make their health decisions without heavily depending on their partners (Uganda Constitutional Court, 2001).

5.6 Cultural and religious barriers

Culture greatly influences lifestyle choices, including health practices, in both positive and negative ways. Health patterns demonstrated that women access, choose and use specific health services, either traditional or professional, in line with their culture. Unfortunately, several cultural practices found in Uganda restrict access and use of modern health care services due to traditional misperceptions, added to by the high costs of professional medical care, the easier access to home remedies, the community endorsement of traditional births and the strict visitation rules in hospitals which limit family support for pregnant women.

The widespread practice of polygamy also creates a multiple of health threats entrenched in patriarchal and subjugating systems against women. It is reported to pressure women to bear children to win the heart of their male partners, with less regard for child spacing or precautions to prevent sexually transmitted diseases ((28 too many, 2013). The tradition of early marriages exposes girls to teenage pregnancies before they are mature enough to support them. Other risk factors include the dangerous cultural rites of passage and initiation into womanhood that young women go through. These include the elongation of the labia minora amongst the Baganda, genital mutilation amongst the Sebei and the Sabiny, the use of herbs for vaginal tightening and making vaginal incisions or tattoos amongst some contemporary female circles. Whereas some men endorse these traditions as they increase their own sexual pleasures, they expose women to severe health complication such as vaginal inflammation, painful abrasions and susceptibility to reproductive diseases (TARSC and HEPS, 2013; UNDP, 2017). Amongst the youngest women, nutritional health and work-life balance are a concern. Twinomugisha (2015) argues that inequitable gender relations make pregnant women overwork despite adverse effects on their pregnancy. In part due to the fact that Ugandan society considers pregnancy as a source of pride and not vulnerability. Working women have less time to breastfeed after their maternity leave than unemployed women and this, with preferences for early weaning, affects their and their baby's health.

In contrast, cultural practices such as strong family support networks could improve the conditions of women struggling to enjoy a work-life balance. In particular, men have the capability to bridge the gap caused by traditional gender roles and inequities through offering their support. Work places and community centres such as churches can also encourage safe mother-child bonding practices by availing private spaces where nursing mothers can breastfeed their children with dignity and at recommended times until the appropriate age for weaning.

Similar to cultural taboos and legislative criminalisation, religion uses the concept of sin to restrict people from enjoying their right and reproductive rights, through both self-surveillance and societal stigma (Tamale, 2014). Uganda is a secular state and Article 29(1) of the Constitution grants the citizens freedom to practice religions of their choice. There are several active religions in Uganda including African Traditional Religion (ATR), Islam and Christianity. Although religions may vary, they are sources of morality and ethical values, including on control of sexuality. Tamale (2014) reports that some religions, particularly Islam and Catholicism, vehemently oppose any discussion of sexuality and contraception within the framework of human rights. For instance, abortion is an abomination under both the Quran and Bible, as their believers deem fetuses human beings and consider it murder. The shift in religious views on this is however signalled by the Vatican recently sanctioning priests to forgive the sin during confessions (Povoledo and Stack, 2016).

Another constraint among some religions is on the enjoyment of sexual and reproductive rights outside marriage, which brands them as sins, and for some such as Catholicism there is a taboo against the use of modern contraceptives. For example one Ugandan priest was reported to have asserted that under the Catholic faith, it is a sin for a mother to abort or for young girls to use contraceptives, even in cases of incest, noting that abortion may only be tolerated where the mother's life is in danger. A 2014 survey among Catholics in twelve countries found support for contraceptives to be at just over 40% of all respondents (The Guardian, 2014).

Other religions are more open to use of contraceptives, but intolerant towards premarital sex and there are reports of religious leaders have called for those engaging in this to apologize for their deeds, and be punished (The Guardian, 2014). Religion thus appears to limit women's ability and right to control their fertility (Tamale, 2016). This is compounded by the fact that the Penal Code Act translates religious sexual sins into legally punishable criminal offences against morality, limiting women from exercising their sexual rights such as safe abortion and family planning services (Tamale, 2016).

5.7 Weak social mobilisation and accountability mechanisms

The findings presented earlier point to an increase in social and civil society mobilisation to hold the government accountable to the realisation of the right to health. However, many of the efforts made for maternal health and menstrual hygiene were dispersed, uncoordinated and often duplicated other efforts. Diversity can be helpful in increasing the scope of impact of citizen action, but it would be helpful if these efforts were synergised and built on the HRBA to health for better results. Improved coordination and knowledge sharing of best-practices will facilitate monitoring and evaluations of the progress made, as well as reduce the costs of service delivery by participating in a more equitable allocation of resources across the country.

Laws and policies on the right to health exist, but most of them lack clear mechanisms to monitor the performance of the duty bearers and means by which to hold them accountable. Most monitoring mechanisms are set out in the subsidiary legislation and, except for professional regulations, most of the laws and policies direct the monitoring towards private sector players and individual citizens instead of the state as the primary duty bearer. For instance, most regulations provide for inspections and submission of operational or compliance reports from the health service providers. In addition, they authorise the regulators to confiscate equipment, shut down health facilities or impose deterrent fines as they deem fit. As a result, patients lose access to basic health care, especially in the remote areas where medical service providers make low investment commensurate to the level of development in the rural areas.

In contrast, government health agencies rely on administrative mechanisms to hold themselves accountable in fulfilling their obligations towards the right to health. Such examples include dispersed or occasional policy and budget reviews, internal or independent audits, project evaluations and impact assessments. Since the monitoring is conducted internally or by persons on contracts issued by the same state agency, there is a likelihood of lenient assessments of performance. Moreover, public institutions do not necessarily prescribe penalties for their failures, while tough sanctions may apply to private actors. Such a double standard should be rectified as the duty to uphold, promote and protect the right to health lies in the first instance on the state.

To that end, judicial implementation and popular constitutionalism need to weigh in and complement the internal assessments. For instance, citizens can appeal to the Parliament to summon the state health agencies who fail to deliver so that they explain their performance and are given precise timelines within which to take corrective actions. CSOs can follow-up on the resolution of complaints reported, conduct budget and expenditure analyses, as well as impact assessments on health especially for the vulnerable communities which may not be prioritized by government.

6. The future of the right to health

This study allowed for the emergence of issues and themes related to constitutionalism in the application of a right to health in Uganda. While the right to health is yet to be explicitly incorporated in the Ugandan constitution, there are thus a number of avenues to its implementation. Seven issues and themes emerged on this from the findings described in the case study. All merit future attention to realise the right the health:

Monitoring and enforcing accountability in the implementation of the right to health

The importance of developing increased accountability was highlighted in the high levels of discrepancy between the international and national intentions of the Ugandan government and the different reality relating to the national budget and conditions of individuals in communities. This theme also includes the complementarity of statutes in enforcing the constitutional right to health, as statutes can serve as accountability mechanisms for citizens.

Developing a multisectoral approach to strengthen political implementation

The Health Sector Development Plan promotes a multi-sectoral response to health promotion, as well as disease prevention. Unfortunately there a no clear guidelines except for disaster preparedness. There is a need for guidelines on integrating multisectoral approaches to plans, and an opportunity to develop comprehensive plans that include how they will work with the health sector. There are undocumented efforts by the health ministry, with support from the Office of the Commissioner on Human Rights to develop a multisectoral strategy to reduce maternal mortality and morbidity in Uganda, in which the authors of this report have participated. We propose the use of international guidelines in this process, such as the Health Equity Programs of Action being developed by Georgetown University, Washington through global consultations (O'Neill Institute, 2017). This can support governments to integrate rights based approaches in a multi-sectoral response.

Financing the health system

The study generally reflects a weakness in the health system, with many of the cases documented pointing to under-resourcing. This points to the need for improved financing, especially at subnational level, and to test their effectiveness in improving the quality, quantity of and equity in service delivery. Any model introduced should be tested for its feasibility in the environment that it is being implemented in, with evaluation to gather evidence of costs and benefits for the right to health. This equally relates to the role of the growing number of private health sector players, especially in the urban areas, and the necessary regulations of this sector to ensure equitable access to quality services and to protect poor people from violations of their right to health in these services. Both instances point to the need for improved awareness in health service providers and the public of the law. It points to the need for sensitization on rights and the law.

Strengthening Judicial implementation

Judicial implementation is referred to as the most common form of constitutional implementation. However in Uganda, there is paucity of jurisprudence and we have reported lack of enthusiasm or understanding. Similarly, there are a few civil society organisations using human rights doctrines in their litigation. The challenge therefore is to create a critical mass of judicial actors with such expertise through continuous sensitisation and engagement in human rights dialogue. Further, we see some evidence of benefit in the appeal process as shown in the constitutional petition 16 where the high court of appeal declared the case justiciable in the constitutional court. This particular case may also be a reflection of the lack of skill to litigate the right to health by judicial officers because it has not been concluded. Notably, this report does not include a case that had been litigated by local organizations at regional or international courts. This would be an opportunity for future litigations on the right to health.

Sustainability of popular implementation initiatives

Popular actions were found to be powerful tools that can both spread a message to create social change amongst the population and create institutional change. Popular processes illustrated in this report were of two types, one led by an individual such as the pad campaign; and the second one by organised groups for a common cause. The former may not be sustainable due to considerable time and resources that are used, and the risk that it may be identified with partisan politics. Campaigns that are linked to partisan politics, such as those described in this case study, may link political rhetoric to advocacy for human rights. However, there are also non partisan civil society groups that have organised themselves to advance the right to health. For example, the industrial action by the medical workers remained health issue focused with a clear message, even in the face of threats by high ranking government officials. Government heeded to some of their demands before they returned to work, while also noting the harm to health from prolonged industrial action. The Coalition to Stop Maternal Mortality in Uganda had a clear message and held government to account for maternal deaths. The advocacy increased public awareness on the right to health, and an apology from a judge for a delayed ruling. These latter actions did not attract a coercive response from the state as others did as they were perhaps perceived to be more focused on the right to health from organized groups without political affiliations, and with the intention to realize positive public and policy outcomes.

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Acronyms

| | |
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| A4C | Activists for Change |
| AIDS | Acquired Immuno Deficiency Syndrome |
| ACHPR | African Charter on People's Rights |
| ACRWC | African Charter on Rights and Welfare of Children |
| CEDAW | Convention on the Elimination of All Forms of Discrimination Against Women |
| CEHURD | Centre for Health Human Rights Development |
| CRC | Convention on the Rights of the Child |
| CRPD | Convention on the Rights of Persons with Disability |
| CSO | Civil Society Organisations |
| EAC | East African Community |
| EQUINET | Regional Network on Health Equity in East and Southern Africa |
| GoU | Government of Uganda |
| ICESCR | International Covenant on Economic, Social and Cultural Rights |
| MDG | Millennium Development Goal |
| MoES | Ministry of Education and Sports |
| MOFPED | Ministry of Finance Planning and Economic Development |
| MOGLSD | Ministry of Gender, Labour and Social Development |
| MOH | Ministry of Health |
| MOLG | Ministry of Local Government |
| SDG | Sustainable Development Goal |
| UBOS | Uganda Bureau of Statistics |
| UDHS | Uganda Demographic Health Survey |
| UHRC | Uganda Human Rights Commission |
| ULRC | Uganda Law Reform Commission |
| UNICEF | United Nations Children's Emergency Fund |
| WHO | World Health Organisation |