UGANDA'S COMPLIANCE WITH THE RIGHT TO HEALTH IN SELECTED HEALTH FACILITIES IN KAMPALA

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Master of Laws

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DECLARATION A

This thesis is my original work and has not been presented for a degree or any other academic award in any university or institution of learning.

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Name and Signature of Candidate

_____

Date

DECLARATION B

I confirm that the work reported in this dissertation was carried out by the candidate under my supervision.

_____

Name and Signature of Supervisor

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Date

APPROVAL SHEET

This thesis report entitled **"Uganda's compliance with the right to health under international law in selected health facilities in Kampala"** prepared by Julieth Tumwebaze in partial fulfillment of the requirements for the degree of Master of Laws has been examined and approved by the panel on oral examination with a grade of PASSED.

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DEDICATION

This thesis is dedicated with much love and appreciation to my dear husband Ssalongo Lule John Kutaymukama and my children Gift Nakato Lule, Blessing Babirye Lule and Mark Male Lule .

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LIST OF ACRONYMS

ACHPR	African Charter on Human and Peoples' Rights.
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
CSO	Civil Society Organization.
EQUINET	Equity in Health in East and Southern Africa
GDP	Gross Domestic Product
HSSP	Health Sector Strategic Plan
IAPA	Industrial Accident Prevention Association
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Convention on Economic Social and Cultural Rights
IMF	International Monetary Fund
IFHHRO	International Federation of Health and Human Rights Organizations
MDGs	Millennium Development Goals
NHP	National Health Policy
PEAP	Poverty Eradication Action Plan
PRSP	Poverty Reduction Strategy Paper
RTH	Right To Health
SPSS	Statistical Package for Social Scientists
UDHR	Universal Declaration on Human Rights
UNHCO	Uganda National Health Consumers / Users Organization
UNGA	United Nations General Assembly
WHO	World Health Organization

LIST OF LEGISLATIONS RECOGNIZING THE RIGHT TO HEALTH

Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, September 1978.

Universal Declaration of Human Rights. United Nations General Assembly Resolution 217 A(III). New York , NY: United Nations 1948.

Charter of the United Nations (1945).

Constitution of the World Health Organization (1946).

United Nations Millennium Declaration

Millennium Development Goals

Declaration of Commitment on HIV/AIDS. UN General Assembly Resolution S-26/2 of 27 (July 2001).

International Covenant on Economic, Social and Cultural Rights. New York , NY: United Nations 1966; art. 12.

International Convention on the Elimination of All Forms of Racial Discrimination. New York , NY: United Nations; 1966: art. 5 (*e*) (iv).

International Covenant on Civil and Political Rights (1966) and its two optional protocols (1966 and 1989)

International Guidelines on HIV/AIDS and Human Rights: 2006 Consolidated Version.

International Federation of Health and Human Rights Organizations 2009.

The 1979 Convention on the Elimination of All Forms of Discrimination against Women and its Optional Protocol (1999): arts. 11 (1) (*f*), 12 and 14 (2) (*b*).

The 1989 Convention on the Rights of the Child and its two optional protocols (2000): art. 24.

The 2006 Convention on the Rights of Persons with Disabilities and its Optional Protocol (2006): art. 25.
African Charter on Human and Peoples' Rights (1981)

Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador) (1988).

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984) and its Optional Protocol (2002).

Copenhagen Declaration and Programme of Action of the World Summit for Social Development. Copenhagen (1995).

Industrial Accident Prevention Association (IAPA) (2008). *A Health and Safety Guideline for Your Workplace; Lighting at the Workplace.*

Vienna Declaration and Programme of Action adopted by the World Conference on Human Rights, held in Vienna, 14–25 June (1993).

THE COSTITUTION OF THE REPUBLIC OF UGANDA 1995

Uganda Health Service Commission (2003)

The Occupational Safety and Health Act (2006)

The National Environment

Public Health Act

National Development Plan

National Health Policy

Health Sector Strategic Plan (HSSP II)

Poverty Eradication Action Plan 2004/05 – 2007/08.

Fact Sheet on Human Rights in Uganda

INTERNATIONAL LEGISLATIONS THAT UGANDA HAS RATIFIED

Uganda is a party to numerous human rights conventions and legal instruments. These include the following:

. The African Charter on Human and People's Rights (African Banjul Charter on Human and Peoples' Rights)

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- . Universal Declaration of Human Rights,
- International Convention on Economic, Social and Cultural Rights 1966
- . International Convention on Civil and Political Rights
- . Convention on Elimination of all forms of discrimination against Women.

- . The Convention against Torture in 1986. Uganda also ratified the First Optional Protocol on the ICCPR with reservations on Article 5.
- . The Convention on the Elimination of Racial Discrimination
- Convention on the Rights of the Child including the two attendant Protocols;

(i) The optional protocol to the convention on the Rights of the child on involvement of children in the Armed Conflict.

(ii) The optional Protocol to the convention on the Rights of the child in the sale of children, child prostitution and pornography.

- . The African Convention on the rights of the child
- The additional Protocol on the Rights and welfare of the Child

. The additional Protocol to the African charter on Human and Peoples' Rights of women in Africa (2003/2005)

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LIST OF CASES

Centre for Health Human Rights and Development (CEHURD) and the families of Sylvia Nalubowa in Mityana and Anguko Jennifer in Arua V Uganda Government. Constitutional Court Case Number 16 of 2011.

The Environmental Action Network Ltd V The Attorney- General National Environment Management Authority (NEMA) (Misc. Application No. 39 of 2001).

ABSTRACT

The purpose of the study was to explore Uganda's compliance with the right to health in the health care facilities in Kampala, Uganda in relation to International law. The objectives were: to establish organizational factors that influence observance of patients' right to health, to determine patients' satisfaction with the health care services provided at the Kampala public health facilities in light of the right to health and to explore the extent to which the health facilities in Kampala observe the right to health. The study adopted qualitative and quantitative design. The research population was 95,177 and a sample of 110 was used including 40 health workers and 70 patients. Purposive and simple random sampling methods were used in selecting the respondents. Survey interviews were used to gather the required data while content analysis of relevant written documents was used to enrich the study. Findings indicated that the organizational factors that affect the observance of the right to health include communication on issues regarding the right to health, management related aspects such as support supervision, motivation and welfare of workers and finally occupational safety of the workers. These factors were found to be having a big influence on the observance of the right to health in health facilities of Kampala Capital City Authority. And the public health facilities in Kampala are fairly contributing to the achievement of the Right to Health despite the shocks caused by certain challenging issues such as corruption and misappropriation of resources. The study recommends that the government needs to take keen interest in developing procedures and strengthening of the systems and structures meant to safeguard the resources set aside for promoting the right to health.

CHAPTER ONE

1.0 Introduction

This chapter presents:- the background to the study, statement of the problem, purpose of the study, objectives of the study, research questions, significance of the study, justification of the study, scope of the study, operational definitions of terms and concepts as well as limitations of the study.

1.1 Background to the Study

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including ... medical care and necessary social services[1].

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without the distinction of race, religion, political belief, economic or social condition[2]. "The right to health can be understood as the right to an effective and integrated health system encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all. Underpinned by the right to health, an effective health system is a core social institution, no less than a court system or a political system.[3]

The underlying Health-care determinants are water, sanitation, food, nutrition, housing, healthy occupational and environmental conditions, education,

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[1] Universal Declaration of Human Rights(Article 25 (1)

[2]WHO Constitution

[3] The United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (2006).Joint Fact Sheet WHO/OHCHR/323.

information, and it can be achieved through the 'AAAQ'; Availability, Accessibility, Acceptability, Quality.[4]

According to the General Comment, the right to health contains four elements:

- *Availability*. Functioning public health and health care facilities, goods and services, as well as programmes in sufficient quantity.
- *Accessibility*. Health facilities, goods and services accessible to everyone, within the jurisdiction of the State party. Accessibility has four overlapping dimensions: non-discrimination, physical accessibility, economical accessibility (affordability) and information accessibility.
- *Acceptability*: All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, as well as sensitive to gender and life-cycle requirements.
- *Quality*: Health facilities, goods and services must be scientifically and medically appropriate and of good quality.

Further, the right to health, like all human rights, imposes on the State Party 3 types of obligations:

Respect: This means simply not to interfere with the enjoyment of the right to health.

Protect: This means ensuring that third parties (non-state actors) do not infringe upon the enjoyment of the right to health.

Fulfill: This means taking positive steps to realize the right to health.

According to the General Comment, the right to health also has a "core content" referring to the minimum essential level of the right. Although this level cannot be determined in the abstract as it is a national task, key elements are set out to guide the priority setting process. Essential primary health care; minimum essential and nutritious food; sanitation; safe and potable water; and essential drugs are included in the core content.

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[4] General Comment No. 14 of the Committee on Economic, Social and Cultural Rights.

Another core obligation is the adoption and implementation of a national public health strategy and plan of action. This must address the health concerns of the whole population; be devised, and periodically reviewed, on the basis of a participatory and transparent process; contain indicators and benchmarks by which progress can be closely monitored; and give particular attention to all vulnerable or marginalized groups.

States Parties must take steps forward in conformity with *the principle of progressive realization.* This imposes an obligation to move forward as expeditiously and effectively as possible, individually and through international assistance and co-operation, to the maximum of available resources. In this context, it is important to distinguish the *inability* from the *unwillingness* of a State Party to comply with its right to health obligations.

Health rights are legally guaranteed by Human Rights Law, protecting individuals and groups against actions that interfere with fundamental freedoms and human dignity. They encompass what are known as civil, cultural, economic, political and social rights. Health rights are principally concerned with the relationship between the individual and the state.

In the aftermath of World War II, the International community adopted the Universal Declaration of Human Rights, 1948[5]. However, the west argued that civil and political rights had priority and that economic and social rights were mere aspirations. The Eastern bloc argued to the contrary that rights to food, health and education were paramount and civil and political rights secondary.

Hence two separate treaties were created in 1966- the International Covenant on Economic, Social and Cultural Rights (ICESCR)[6] and the International Covenant on Civil and Political Rights (ICCPR). Since then,

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[5] Universal Declaration of Human Rights. United Nations General Assembly resolution 217A (111),(1948).

[6] Craven M. 'The International Covenant on Economic, Social and Cultural Rights'. A perspective on its Development. (1995).

numerous treaties, declarations and other legal instruments have been adopted and it is these instruments that encapsulate health rights.

Uganda is a signatory to a number of International Human rights instruments. However, notwithstanding, the Government of Uganda has not fully subscribed to the full protection of the right to health although it is outlined in the National objectives and Directive Principles of state policy (Constitution 1995: XX, XXI.XXII)[7]. The provisions here in reflect a commitment but do not amount to an obligation since they fall outside the substantive sections of the constitution. Consequently the right to health is neither appreciated nor understood with in the medical and legal ethics. Yet governmental obligations with regard to health rights broadly fall under the principles of respect, protect and fulfill.

Although the National Health Policy mentions 'equity', 'fair play', 'justice', it does not expressly address the more important questions health rights. Moreover, there is a host of underlying determinants that undermine the realization of Health rights in Uganda's health facilities.

These are inadequate social infrastructure, poor remuneration of health workers, lack of adequate training of Health workers, insecurity of some parts of the country, inadequate funding of health sector, a non-rights-based training curricula, ignorance and corruption.

The research on right to health was prompted by some reports about mistreatment of patients and attendants in health facilities. There are reports of patients dying in the queue before being attended to, or patients being given drugs without adequate explanation about their effects. There are also

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[7] XX. Medical Services. The State shall take all practical measures to ensure the provision of basic medical services to the population.
XXI. Clean and Safe Water. The State shall take all practical measures to promote a good water management system at all levels.
XXII. Food Security and Nutrition. The State shall-
(i) take appropriate steps to encourage people to grow and store adequate food;
(ii) establish national food reserves; and
(iii) encourage and promote proper nutrition through mass education and other appropriate means in order to build a healthy State.

allegations of patients dying because of neglect and negligence of health workers and relatives or next of kins did not know where to complain.

The research therefore, explored what Uganda's position is in complying with the right to health under International law is.

1.2 Statement of the Problem

Despite record investment over the past five years, Uganda's healthcare performance is still ranked as one of the worst in the world by the World Health Organization. The country is ranked 186th out of 191 nations. A story played out across the country shows that only 38% of healthcare posts are filled in Uganda. Those healthcare staff who are working, have little incentive to work in poor rural areas with 70% of Ugandan doctors and 40% of nurses and midwives based in urban areas like Kampala, serving only 12% of the Ugandan population. A Ugandan's health and life expectancy is among the lowest across the globe. In Uganda, one in every 200 births ends the mother's life, around 1 million people are living with HIV and although malaria accounts for 14% of all deaths, less than 10% of children under five are sleeping under insecticide-treated nets.

The right to health does not mean the right to be healthy. It means that governments must generate conditions in which everyone can be as healthy as possible. Such conditions range from ensuring availability of health services, healthy and safe working conditions, adequate housing and nutritious food.

The right to health has been enshrined in numerous international and regional human rights treaties as well as national constitutions all over the world. Steps for the realization of the right to health include those that:

1. reduce infant mortality and ensure the healthy development of the child;
2. improve environmental and industrial hygiene;
3. prevent, treat and control epidemic, endemic, occupational and other diseases;
4. create conditions to ensure access to health care for all.[8]

[8] Article 12 of the International Covenant on Economic, Social and Cultural Rights (1966) .

To clarify and operationalize the above provisions, the UN Committee on Economic, Social and Cultural Rights which monitors compliance with the ICESCR adopted a General Comment on the Right to Health in 2000.

The General Comment sets out that the right to health extends not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions and access to health-related education and information, including on sexual and reproductive health.

Given the centrality of health as a vital feature of the human condition, health has been recognized as a human right in numerous international documents and Uganda is a party to these human rights treaties that deal with health-related rights. It has been noted that although the right to health is vital and its enjoyment is dependent and closely related to other rights such as life, freedom from torture, freedom from association, assembly and movement, little has been done in regard to this. Even though Uganda has ratified many International Instruments providing for the right to health, the constitution of Uganda does not provide for the right to health in its bill of rights and only mentions it in the national objectives and directive principles of state policy. However, the government, through Poverty Eradication Action Plan (PEAP) and health policy is committed to the right to health, but health has been underplayed in Uganda and yet it plays a critical role in reduction of poverty.

The Health Sector Strategic Plan (HSSP) II has also put in place interventions to promote community empowerment and participation.

The code of conduct and ethics for health workers[9] provides the legal framework for the conduct of health workers in relation to their responsibility

[9] Health Service Commission (2003).

to clients, the community, colleagues and their employer, the government. The emphasis is on responsibility and respect to safeguard the safety and interests of the clients and the public based on ethical standards and technical training.

The purpose of this research therefore, was to find out if Uganda is moving towards a universal recognition of the right to health under International Law.

1.3 Purpose of the Study

Considering the situation in the world today and Uganda, in particular, the researcher deemed it necessary to explore Uganda's compliance with the right to health in the health care facilities in Kampala in relation to International law.

1.4 General Objective

To establish the extent to which health care facilities in Kampala comply with the right to health and factors influencing its observance in light of International Law.

1.5 Specific Objectives

1) To establish organizational factors that influence observance of patients' right to health.
2) To determine patients' satisfaction with the health care services provided at the public health facilities in light of the right to health.

3) To explore the extent to which the health facilities in Kampala observe the right to health.

1.6 Research Questions

1) What are organizational factors influencing observance of patients' right to health?
2) What is the patients' level of satisfaction with the health care services provided at the public health facilities in light of the right to health?
3) To what extent do the health facilities in Kampala observe the right to health?

1.7 Scope of the Study

The research endeavored to establish organizational factors that influence observance of patients' right to health, patients' satisfaction with the health care services provided at the public health facilities in light of the right to health and explored the extent to which the health facilities in Kampala observe the right to health.

1.8 Significance of the Study

The findings of this research are of benefit to the government of Uganda and Non-governmental organizations, agencies, the local community, healthcare providers, educational institutions, researchers and the general public. The findings will be used in improving and designing policies and programs, and in the implementation of programs both for the public and private institutions and training institutions of healthcare workers, that will endeavor to promote the right to health. This will subsequently lead to a healthy living and good quality of life.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter presents review of literature related to the right to health, international treaties and instruments that spell out the right to health and also explores the development of health as an international human right under International law.

In recent years, there have been considerable developments in international law with respect to the normative definition of the right to health, which includes both health care and healthy conditions. These norms offer a framework that shifts the analysis of issues such as disparities in treatment from questions of quality of care to matters of social justice. Building on work in social epidemiology, a rights paradigm explicitly links health with laws, policies, and practices that sustain a functional democracy and focuses on accountability. In Uganda, framing a well-documented problem such as health disparities as a "rights violation" attaches shame and blame to governmental neglect.

The right to health is a fundamental part of our human rights and of our understanding of a life in dignity. *The right to the enjoyment of the highest attainable standard of physical and mental health*, to give it its full name, is not new. Internationally, it was first articulated in the 1946 Constitution of the World Health Organization (WHO), whose preamble defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"[10].

The first notion of a right to health under international law is found in the 1948 Universal Declaration of Human Rights (hereafter called

[10]....the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. *WHO Constitution Preamble.*

Declaration), which was unanimously proclaimed by the UN General Assembly as a common standard for all humanity[11].

The Declaration sets forth the right to a "standard of living adequate for the health and wellbeing of himself and his family, including medical care and the right to security in the event of sickness, disability or other lack of livelihood in circumstances beyond his control[12].

The right to health was included in the International Covenant on Economic, Social and Cultural Rights (ICESCR)[13]. Article 12 of the ICESCR explicitly sets out a right to health and defines steps that states should take to "realize progressively" "to the maximum available resources" the "highest attainable standard of health," including "the reduction of the stillbirth- rate and of infant mortality and for the healthy development of the child"; "the improvement of all aspects of environmental and industrial hygiene"; "the prevention, treatment and "the creation of conditions which would assure to all medical service and medical attention in the event of sickness."

Public health law is another branch of jurisprudence which deals with application of common and statutory law to the principles and practice of public health, to safeguard the population from harm. Public health law applies legal tools - legislation, regulation, litigation and international law - as instruments of public health.

Public health is based on the notion that 'the truths of science will be used to benefit everyone' (Foege, 2004). It addresses health at population level.

Public health includes:

a) Assessment and monitoring of the health of communities and populations at risk; and

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[11] UDHR (n 5) .UNGA Resolution 217A(111), (1948).

[12] Ibid. Article 25

[13] Craven M. (n 6).

b) Formulation of public policies to promote health, prevents disease, provide access to appropriate and cost-effective care, and evaluate the effectiveness of care.

The scope of public health has shifted from a traditional focus on disease eradication, surveillance, screening, sanitation and treatment. It now covers new social and environmental determinants of health, as well as risks across national borders, including preparedness for global pandemics, health effects of trade, bioterrorism and trans-border movement of hazardous substances. Public health draws on four principles and approaches:

I. Prevention is prioritized.

This includes:

a) primary prevention of disease and disability (e.g. immunization);

b) secondary prevention for early detection of problems (e.g. screening for sexually transmitted diseases or tuberculosis); and

c) tertiary prevention to limit disease impacts (e.g. investigating food-borne outbreaks).

II. Direct involvement of communities in health action is promoted, such as in the promotion of youth reproductive health.

III. Actions are chosen that have widest collective gain. Hence, measures that reduce collective exposure to water borne disease through provision of safe water are preferred to treating individuals for water borne diseases.

IV. Methods for investigating the distribution and determinants of disease at community level (i.e. epidemiology) are used to identify causes and plan intervention.

Equity in health includes concepts of fairness and justice. It implies that everyone should have a fair opportunity to attain their full health potential[14], and that the primary determinant in access to health inputs should be health needs, and not factors such as status, gender, ethnicity, insurance, housing and disability.[15] The notion of equity is recognized by the Uganda National Health Policy, but it does not expressly address the more important questions of health rights.

Access to health care is equitable if there are no information, financial, or supply barriers that prevent access to a reasonable level of health care[16]. According to EQUINET, equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In east and southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). Laws and policies are amongst the possible tools that exist to ensure the redistribution of societal resources towards these outcomes. Gaps in the laws protecting public health can leave people with inadequate information to promote health, undermine their power and means to manage risks to health, or to ensure a fair distribution of resources for health according to need. This means that strengthening public health law can contribute to health equity.

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[14] Whitehead M (1990) 'The concepts and principles of equity and health,' a report. WHO Regional Office for Europe: Copenhagen.

[15] Berman, Peter (2004 'The Household Production of Health: Integrating Social Science Perspectives on Micro-level Health Determinants' Journal of Social Science and Medicine; Utrecht, Netherlands. Volume 63, Issue 4, August (2006), Pages 920-932.

[16] EQUINET SC 2007

2.1 CONCEPTS, IDEAS, OPINIONS FROM AUTHORS/EXPERTS

The 1948 Universal Declaration of Human Rights mentioned health as part of the right to an adequate standard of living.[17] The right to health was again recognized as a human right in the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR), and it was the first human rights treaty to require states to recognize and realize progressively the right to health, and it provides key provisions for the protection of the right to health in international law.[18]

Since then, other international human rights treaties have recognized or referred to the right to health or to elements of it, such as the right to medical care.

The broad definition of health implied by the right to health encompasses both the curative and preventive aspects of health. It has been said that this dual focus corresponds with the distinctive perspectives of clinical medicine and public health, both of which have influenced how the right to health has been defined and evolved. Whereas clinical medicine has traditionally focused on the health status of individuals, public health has focused on the need to promote and protect the health of populations and to ensure conditions under which people can be healthy and remain so.

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[17] Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. *UDHR Article 25(1*

[18] 1 The States parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2 The steps to be taken by the States parties ... to achieve the full realization of this right shall include those necessary for:
(a) The provision for the reduction of the still birth rate and of infant mortality and for the healthy development of the child;
(b) The improvement of all aspects of environmental and industrial hygiene;
(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
(d) The creation of conditions which would assure to all medical services and medical attention in the event of sickness. *ICESCR Article 12.*

The right to the highest attainable standard of health takes account of the holistic approach to health that regards both health care and social conditions as being important determinants of health status. These include the provision of safe drinking water, adequate sanitation, and health-related education and information, as well as others such as equitable health-related resource distribution, gender differences and social well-being. They also include socially related events that are damaging to health, such as violence and armed conflict.[19] The Committee on Economic, Social and Cultural Rights, the body responsible for monitoring the International Covenant on Economic, Social and Cultural Rights[20], calls these the "underlying determinants of health".

The right to health should not be seen as a right to be *healthy*. The state cannot be expected to provide people with protection against every possible cause of ill health or disability such as the adverse consequences of genetic diseases, individual susceptibility and the exercise of free will by individuals who voluntarily take unnecessary risks, including the adoption of unhealthy lifestyles. The right to health should be understood as a right to the enjoyment of a variety of facilities and conditions which the state is responsible for providing as being necessary for the attainment and maintenance of good health.

It is helpful to view the right to health as having two basic components:

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[19] ... the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.
... [It is] an inclusive right extending to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels. *CESCR General Comment 14, paras 9 and 11*

[20] The Covenant was adopted by the United Nations General Assembly in its resolution 2200A (XXI) of 16 December 1966. It entered into force in 1976 and by 1 December 2007 had been ratified by 157 States.

a right to health care and a right to healthy conditions.[21]

'The right to health does require governments and public authorities to put in place policies and action plans which will lead to available and accessible health care for all in the shortest possible time. To ensure it happens is the challenge facing the human rights community and public health professionals.'[22]

For the case of Uganda, the government has constructed health centers in almost every parish in addition to upgraded health centers with theatres at sub-county levels. But these lack health care workers and drugs to run them.

The right to health contains freedoms. These freedoms include the right to be free from non-consensual medical treatment, such as medical experiments and research or forced sterilization, and to be free from torture and other cruel, inhuman or degrading treatment or punishment.

The right to health contains entitlements which include:

a. The right to a system of health protection providing equality of opportunity for everyone to enjoy the highest attainable level of health;
b. The right to prevention, treatment and control of diseases;
c. Access to essential medicines;
d. Maternal, child and reproductive health;
e. Equal and timely access to basic health services;
f. The provision of health-related education and information;
g. Participation of the population in health-related decision making at the national and community levels.

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[21] ... the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic, or social condition. *WHO Constitution Preamble.*

[22] Mary Robinson, former UN High Commissioner for Human Rights

Health services, goods and facilities must be provided to all without any discrimination. Non-discrimination is a key principle in human rights and is crucial to the enjoyment of the right to the highest attainable standard of health. States have an obligation to prohibit and eliminate discrimination on all grounds and ensure equality to all in relation to access to health care and the underlying determinants of health.[23]

All services, goods and facilities must be available, accessible, acceptable and of good quality. This requires, in particular, trained health professionals, scientifically approved and unexpired drugs and hospital equipment, adequate sanitation and safe drinking water.

Numerous conferences and declarations, such as the International Conference on Primary Health Care (resulting in the Declaration of Alma-Ata[24]), the United Nations Millennium Declaration and Millennium Development Goals,[25] and the Declaration of Commitment on HIV/AIDS[26], have also helped clarify various aspects of public health relevant to the right to health and have reaffirmed commitments to its realization.

2.2 Obligations of States towards the Right to Health

The right to health is relevant to all States: every State has ratified at least one international human rights treaty recognizing the right to health. Moreover, States have committed themselves to protecting this right through international declarations, domestic legislation and policies, and at international conferences.

States have the primary obligation to protect and promote human rights. Human rights obligations are defined and guaranteed by international

23 ICERD (Article 5)... States must prohibit and eliminate racial discrimination and guarantee the right of everyone to public health and medical care.

24 Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, September (1978).

25 See http://www.un.org/millenniumgoals/.

26 General Assembly resolution S-26/2 of 27 July 2001.

customary law[27] and international human rights treaties, creating binding obligations on the States that have ratified them to give effect to these rights.

By ratifying international human rights treaties that affirm the right to health, a state agrees to be accountable to the international community, as well as to the people living within its jurisdiction, for the fulfillment of its obligations. Indeed, the legal recognition of the right to health is important precisely because it allows the right to be claimed by individuals and groups. In view of this, States parties to an international human rights treaty are required specifically to adopt legislative measures and to employ all appropriate means to ensure that the population can enjoy the rights conferred by the treaty. This entails ensuring that international treaty provisions are incorporated into domestic legislation and that, individuals and communities have access to effective judicial or other appropriate remedies in the face of violations of their rights.

Under international law, states that are party to a variety of different treaties assume tripartite obligations:

(1) To ***respect*** the right to health by refraining from direct violations, such as systemic discrimination within the health system. Respecting the right to health applies mainly to government laws and policies and requires that states refrain from undertaking actions that inhibit or interfere (directly or indirectly) with people's ability to enjoy the right to health, such as by introducing actions, programmes, policies or laws that are likely to result in bodily harm, unnecessary morbidity, and preventable mortality.

(2) To ***protect*** the right from interference by third parties, through such measures as environmental regulation of third parties. In practice, this means that states are responsible for regulating the conduct of individuals and groups who are working in the non-governmental sector and for

[27] Customary law is evidence of a general practice of States accepted as law and followed out of a sense of legal obligation.

protecting people's right to health through legislative and other measures; and

(3) To ***fulfill*** the right by adopting deliberate measures aimed at achieving universal access to care, as well as to preconditions for health. Thus, it is wrong to think of the right to health in terms of a package of services, even a package extending beyond medical care.[28]

Fulfilling the right to health applies to positive measures that governments are required to take, such as by providing relevant services, to enable individuals and communities to enjoy the right to health in practice. It also requires that special measures be taken to prioritize the health needs of the poor and otherwise vulnerable and disadvantaged groups in society.

As with all international human rights, implementation and enforcement of the right to health critically depend on legislative and judicial action at the national level.

Promoting and protecting health and respecting, protecting and fulfilling human rights are inextricably linked:

- Violations or lack of attention to human rights can have serious health consequences (e.g. harmful traditional practices, slavery, torture and inhuman and degrading treatment, violence against women and children).
- Health policies and programmes can promote or violate human rights in their design or implementation (e.g. freedom from discrimination, individual autonomy, rights to participation, privacy and information).
- Vulnerability to ill-health can be reduced by taking steps to respect, protect and fulfill human rights (e.g. freedom from discrimination on account of race, sex and gender roles, rights to health, food and nutrition, education, housing).

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28 'Concluding Observations of the Committee on ESCR: Ecuador. Geneva, Switzerland: United Nations; 2004. Accessed March 28, 2011.

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being. Yet millions of people have no access to health-care or even basic sanitation. Faced with this reality, people living in poverty often feel powerless. Unaware of their human rights, they are resigned to the fact that health services are too far away or cost too much. Those lucky enough to access health services are often treated badly. All this has to change. People need to be more aware of their rights so that they can take more control over their lives. Only then can effective action be generated to hold governments, and other powerful actors, accountable.[29]

2.3 The Uganda's situation

Uganda is a signatory to the Human Rights Charter, and the 1966 UN Convention on Economic, Social and Cultural Rights. As a partner to the IMF and World Bank, and a southern party to most bilateral covenants, it also subscribes to the Millennium Declaration, which seeks to achieve the following goals:

1. Eradicate extreme poverty and hunger;
2. Achieve universal primary education;
3. Promote gender equality and empower women;
4. Reduce child mortality;
5. Improve maternal health;
6. Combat HIV and AIDS, malaria, and other diseases;
7. Ensure environmental sustainability; and
8. Develop a global partnership for development.

The PEAP framework was adopted as the PRSP and sets out the four pillars for development. Poverty has been declining, and only 35 percent of Ugandans are absolutely poor, compared to more than 50 percent two decades ago. GDP growth is more stable at 5 percent per annum, although it has dropped from 8

[29] Gro Harlem Brundtland Director General WHO, Geneva, September (2002).

percent in 1990, and the policy of Universal Primary Education is in operation, ensuring better literacy levels. It is certain that, over the past two decades, almost all indicators have improved.

However, with the population growing at 2.8 percent per annum, infant mortality rate at 91/1000, and 55 percent of children not immunized, together with a high teacher-pupil ratio in schools, there still remains a lot to do. Unemployment is high and incomes are too low.

The setting up of Health centers with maternity wards is step towards curtailing Maternal mortality, but these need to be staffed with competent and well motivated medical personnel.

There has been a move to provide anti-retroviral drugs for HIV positive people at a subsidized price and Uganda has a record in sensitization that has reduced the rate of new HIV infections. But, at 70 000 deaths from HIV and AIDS annually, it is still high and more needs to be done.

Even though Uganda has ratified many International Instruments providing for the right to health, the constitution of Uganda does not provide for the right to health in its bill of rights and only mentions it in the national objectives and directive principles of state policy. The constitution of Uganda (1995) only states in article 39 that 'Every Ugandan has a right to a clean and healthy environment'.

A glance at the news papers in this country today shows glaring outright violations of the health rights in various forms and at different levels of healthcare.

Delivery violations include neglect, denial of services and poor attitude resulting into vulnerability, morbidity, disability, stigma and discrimination among others. A number of articles show child related scenarios of health rights abuses which are due to the bad health care system, negligence of some health workers or even the care takers /parents.

'Child burns rot fingers cut off' is an example of gross violation of health rights due to negligence which has led to disability and deformity.[30]

'A baby loses hand to quinine injection' is another such scenario. And in this case, no body bothered to know whether the drugs were expired, the medical personnel was qualified, the baby was legible for Quinine injection, the quinine injection was the best alternative, the medical personnel showed concern to what happened and whether the baby got redress or not.[31]

The other area of health rights violations is neglect of patients by health personnel, which has affected services utilization and undermined the efforts of health program interventions. This is evidenced in the various articles;

'Few medics tell, counsel patients about their sicknesses.' Some of the issues raised in this article were inadequate information to the patients on their illnesses and patients are not offered treatment options and / or a chance to have a say on the choice of medication. Overall, more than half the patients are not told of the kind of illness they were suffering from, so they walked out just as ignorant as they went in.'

'An eight months pregnant mother who had been induced for an emergency delivery, lay in the labor ward with no one telling her whether the baby was alive or not, neither did she know what kind of drugs the doctors were giving her. She had asked but the health workers refused, saying she was not a doctor and therefore would not understand the information'.[32]

Negligence in healthcare delivery has also been revealed in the 18th August Monitor where by the 'Doctor's silent phone causes patient's death'. This article suggests negligence on the doctor's side, the patient's caretakers and laxity on the system[33]. But, if the doctor's phone was in silent and she could not be reached, was she the only doctor on duty? What did the hospital

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[30] Raphael Okello Luganda New Vision August 26th (2002) page 29.
[31] David Mafabi, Sunday Monitor August 20th (2006) .
[32]Charles Wendo (27th August 2002) page 31.
[33] Bakyawa Jenifer and Kiiza Irene. Monitor (18th August 2003).

do about emergency? Did caretakers report to the administration about non-response of the doctor?

News all over in the electronic and print media portray the level at which the country respects this fundamental right.

Following the Global Fund saga that left the treasury for HIV and Tuberculosis funds depleted by the prominent politicians in the country, a number of events have occurred.

Mulago National Referral Hospital's failed to account for over five Billion Uganda shillings in addition to the perpetual lack of drugs and poor service delivery to the Ugandan population. This is evidenced by the Hospital's inability to repair the only radiotherapy machine that broke down in 2010 that led to hundreds of cancer patients waiting for weeks without treatment. [34]

The hospital recently made headlines when at least ten patients lost their lives as a result of power cut and oxygen stock out.

In February 2011, patients admitted with the spinal injuries went on strike demonstrating against lack of medical attention for over six months, waiting to be operated upon.

Furthermore, over ten health centers in two districts of Agago and Pader in Northern Uganda remained closed due to lack of drugs and health workers. These have grass overgrown around them and others have become housing units for chicken, cattle and goats. As one lady from one of the districts reported, each time they fall sick they have to walk about 10 kilometers to the near by town to get treatment. Yet these health centers are closer to them and they would be able to get help even at night.[35]

[34] The National News paper (The New Vision). (March 29,2011) page 10
[35] ibid page 6.

The Health Rights week held between 5th to 10th December 2006, spearheaded by the UNHCO , included a petition to the speaker of parliament , a procession and presentations. The petition was on increasing health funding from 9 – 15% of GDP and highlighted the poor human development indicators including:

A. Poor infant and maternal mortality rates of 83 per 1000 live births and 505 per 100,000 respectively,
B. low access to HIV/AIDS services,
C. low Human resources for health of 5 per 100,000 people,
D. constant drug stock outs,
E. corruption and
F. poor monitoring and evaluation of health goods and services[36].

UNHCO National Coordinator therefore appealed to the health consumers / users to take up their responsibility and demand as well as exercise their health rights so as to contribute to improved Health care in the country.

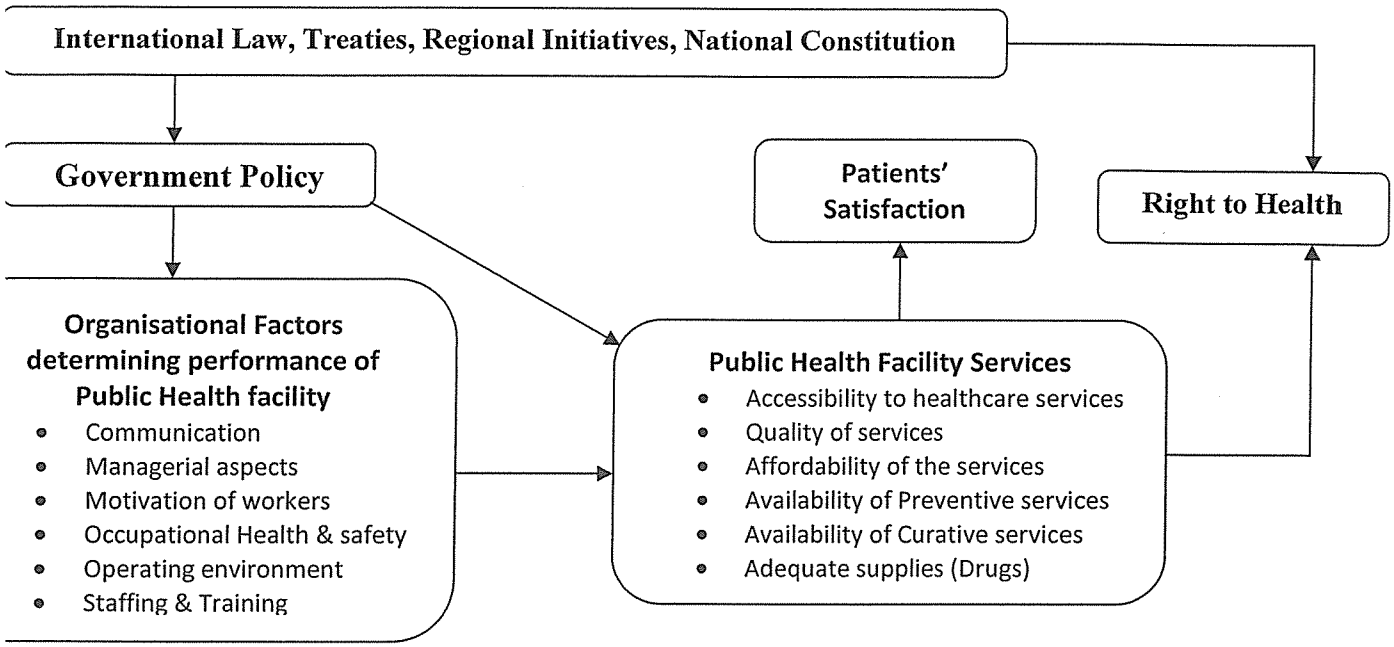
Although the National Health Policy mentions 'equity', 'fair play' and 'justice', it does not expressly address the more important questions of Health Rights. Moreover, there is a host of underlying determinants that undermine the realization of health rights in Uganda's health facilities.

However, it has been noted that although the right to health is vital and its enjoyment is dependent and closely related to other rights such as life, freedom from torture, freedom from association, assembly and movement, little has been done in regard to this.

Therefore in such circumstances, as a student of Public International Law as well as a Ugandan, I needed to find out from relevant persons the extent to which Uganda complies with the Right to Health as a fundamental human right under International Law.

[36] UNHCO Health rights week report. (2006.)

CONCEPTUAL FRAMEWORK



International framework regarding the promotion and protection of the right to health as a human right stands as the independent variable. This includes regulations and treaties set from the international platform. These determine the government's policy framework under whose management are the public health facilities. Government has influence on the organizational factors and healthcare services provided in the public health facilities. The nature of services provided in these facilities determine the patients' level of satisfaction but most importantly, the extent to which public health facilities observe the right to health of individuals, which stand as the dependent variable.

Human rights are interdependent, indivisible and interrelated. This means that violating the right to health may often impair the enjoyment of other human rights, such as the rights to education or work, poverty, and vice versa.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

In this section, instruments and procedures for data collection that were used such as the research design; the study population and the sampling techniques, the methods for data collection, data analysis, research questions, ethical considerations and research procedure are explained.

3.1 Research Design

The design used for this study was based on case study for which qualitative and quantitative data was collected through distinct methods, which included interviews of the patients and healthcare workers in different health facilities in Kampala city. The goal was to receive qualifying information from all the groups in order to provide a clear picture of the problem and possibly identify methods for solving it.

3.2 Research Population

The study studied health workers and patients in the seven Kampala Capital City Authority health facilities of Kiswa Health Centre in Nakawa division, Kiruddu and Kisugu Health Centres in Makindye division, Kisenyi Health Centre in Central division, Kawempe and Komamboga health centres in Kawempe division and Kawaala Health Centre in Rubaga division. The target population was 95,177 (94,927 patients/clients [37] and 250 healthcare workers). The goal of a sample population was to be an accurate representation of the population but in a smaller number.

[37] Population per health unit is estimated at 13,561 (MOH Resource Centre)

3.3 Sample Size

The sample size was 110, and this was distributed among the two categories of respondents (40 healthcare workers and 70 health consumers/clients/patients). To arrive at this sample size, Roscoe's rules of thumb for determining sample size[38] was put into consideration:

1. Sample size larger than 30 and less than 500 are appropriate for most research.
2. Where samples are to be broken into sub samples; (male/females, juniors/seniors, etc.), a minimum sample size of 30 for each category is necessary.

3.4 Sampling Procedure

This presents the sampling method that was used in the study to get the desired information from the entire population under the study.
The health workers were purposively sampled because they acted as key informants on the aspect of the right to health in the health facilities. The patients were randomly sampled as beneficiaries to the facilities being studied.

3.5 Research Instrument and Data Gathering Procedures

The collection of data occurred primarily through the questionnaire system, edited, coded and immediately entered into the computer through SPSS (Statistical Package for Social Scientists). A standard list of questions relating to the problem under investigation was prepared. Specific questions were formulated and constructed for the different categories of respondents; patients and healthcare providers.

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[38] Roscoe (1975)

The study also used content analysis where documents containing information regarding the right to health were reviewed and the relevant information included among the findings and the literature review section.

3.6 Data Analysis

After collection, qualitative data was coded, organized into themes and entered and analyzed with SPSS. Quantifiable data was used to construct frequency and percentage tables as well as generation of charts and graphs which were used during the presentation of findings.

3.7 Limitations

The major challenge was that some of the healthcare providers were too busy to complete filling in of the questionnaires and they were not sure that the questionnaire results would be used only for academic purposes. But the permission taken from the University administration eased their worries.

3.8 Ethical Considerations

Given that it involves people's views, this research was conducted ethically; this included the responsibility of the researcher to protect the privacy of the individuals that participated in the study. This privacy protection extended to all peoples, regardless of age and category.

CHAPTER FOUR

PRESENTATION AND DISCUSSION OF FINDINGS

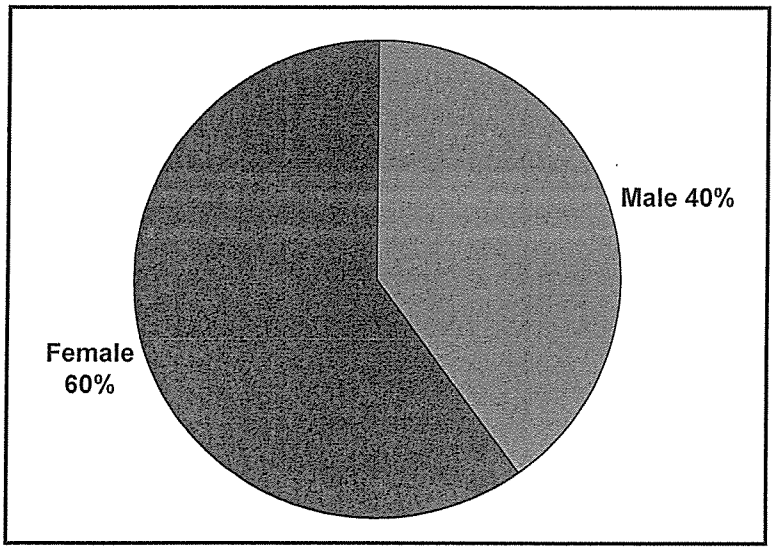
4.0 Introduction

This chapter entails presentation of the major findings of the study. Besides frequency and percentage tables, the presentation includes graphical expressions such as charts and graphs for the quantifiable data. Importantly, the presentation observes the order by which the study objectives were stated.

4.1 Demographic Characteristics of the Respondents

These reflect the socioeconomic features of the sampled respondents. They are intended to get us acquitted with the background characteristics of the sampled population.

Figure1: Gender of sampled patients



Source: *Field Interviews*

A considerable proportion of the sampled respondents were female while the male accounted for 40%. This nearly reflects the actual proportions of patients (female: male) who seek for health care services from public health facilities in Uganda. This makes the sample fairly representative in terms of gender.

Table 1: Age of sampled Health workers

Age	Frequency	Percent
20-29	28	70
30-39	8	20
50-59	4	10
Total	**40**	**100**

Source: *Field Interviews*

According to age, majority of the sampled health workers (70%, n=28) were between the age of 20 to 29 years, followed by 20% of those who were between the age of 30 to 39 years. Only 10% (n=4) of the health workers were between 50 to 59 years of age. This is a youthful sample of respondents whose energy at work is hoped should contribute considerably to meeting the right to health.

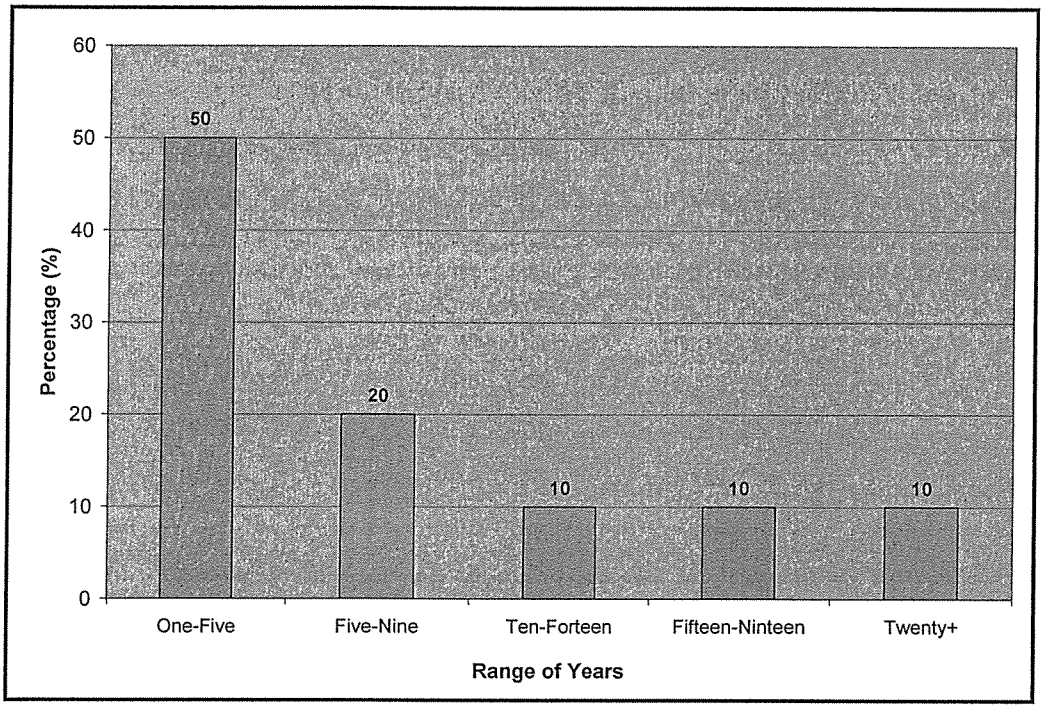
Table 2: Education level of sampled Health Workers

Education	Frequency	Percent
Certificate	16	40
Ordinary Diploma	8	20
Degree	16	40
Total	**40**	**100**

Source: *Field Interviews*

There were equal proportions of those respondents who indicated their highest education levels as certificate (40%, n=16) and Degree (40%, n=16). Only 20% (n=8) of the respondents held ordinary diplomas as their highest level of education. Again, this sample of health workers was fairly balanced and gives the study opportunity to gather views from different categories of respondents in the health field with distinct levels of education.

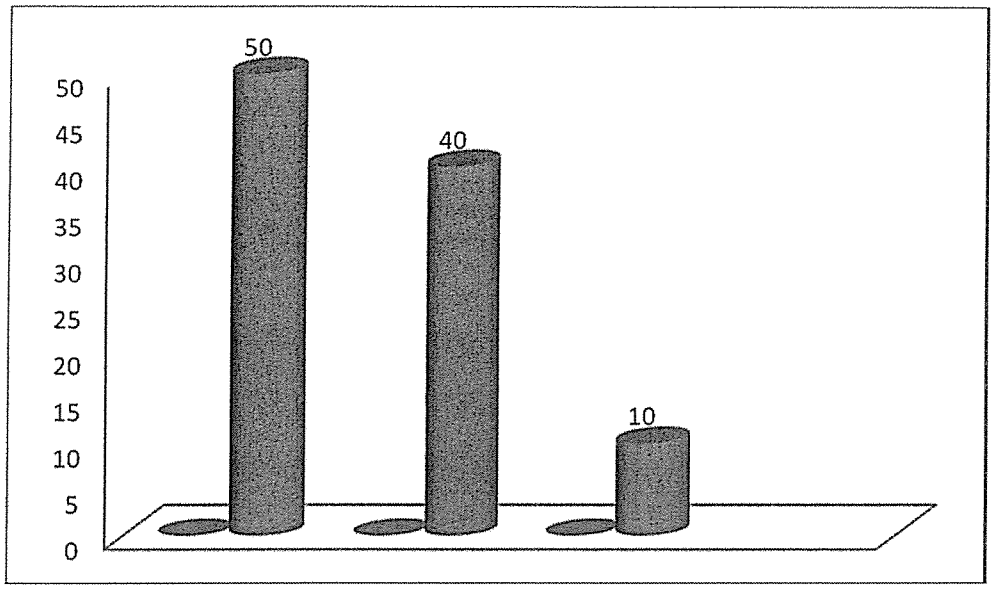
Figure 2: Length of time of Service at the Health facility



Source: *Field Interviews*

As regards length of service by the health workers, half (50%, n=20) had served for between one and five years, followed by 20% (n=4) who had served for between five and nine years. The rest of the sampled health workers had served for between ten and fourteen, fifteen and nineteen and twenty years and above, each with an equal proportion of 10%. The length of service provides a reliable level of assurance that the data gathered for the study was got from experienced respondents.

Figure 3: Frequency of use of Healthcare services by the consumers



Source: *Field Interviews*

Half of the patients (50%) indicated that they access healthcare services every month, followed by 40% who indicated that they seek for the services once in every three months. Lastly, 10% of the patients showed that they seek for health care services once in six months. Since majority of the sampled patients use health care services more frequent than not, it made them the right sample for the study.

4.2 OBJECTIVE 1: ORGANIZATIONAL FACTORS THAT INFLUENCE OBSERVANCE OF PATIENTS' RIGHT TO HEALTH

This formed the first objective of the study. The issues captured under this objective included communication within the organization on certain areas regarding the right to health, management related aspects such as support supervision, motivation and welfare of workers and finally occupational safety of the workers. These are presented and discussed as follows:

4.2.1 Communication

The study set to establish whether there is written documentation regarding rules, regulations and guidelines to be followed by workers in executing their duties in light of the right to health of their patients.

Table 3: Whether there are written Rules, Regulations and Guidelines regarding the Right to Health

Response	Frequency	Percent
Strongly Agree	20	50
Agree	8	20
Not Sure	4	10
Disagree	4	10
Strongly Disgaree	4	10
Total	**40**	**100**

Source: *Field Interviews*

The findings indicated strong agreement among 50% of the respondents (health workers) to the existence of documented rules, regulations and guidelines regarding the Right to Health. These are very important given that in their presence, workers can always refer to them in the daily execution of their tasks while observing the right to health of their patients.

Table 4: Whether the Employer provides workers with information on the Right to Health

Response	Frequency	Percent
Strongly Agree	12	30
Agree	20	50
Not Sure	4	10
Disagree	4	10
Total	**40**	**100**

Source: *Field Interviews*

On this matter, a sizeable proportion of the sampled health workers (50%, n=20) indicated their agreement to the fact that the employer/health facility provides information about the right to health to the health workers. This is further affirmed by another proportion of 30% (n=12) who strongly agreed to the same issue. Only 10% (n=4) disagreed. The common information vehicles that workers need include posters, fliers and handbooks on a health workers role in observing the right to health when on duty.

In accordance to the above, the PEAP observes that participation and access to information are necessary conditions for the well-being of a population and for enhancing human development. Human development for that matter and most importantly, involves health of the individuals.

4.2.2 Managerial issues

These briefly included support supervision of the work done by the health facility managers, training of staff regarding the right to health and the daily time dedicated to work by each health worker on job.

Table 5: Whether there is Support Supervision of Work at the health facility

Response	Frequency	Percent
Strongly Agree	4	10
Agree	4	10
Not Sure	4	10
Disagree	4	10
Strongly Disagree	24	60
Total	**40**	**100**

Source: *Field Interviews*

Majority of the sampled health workers (60%, n=24) indicated poor support supervision practices at the health facilities by strongly disagreeing to the statement that inquired to find out whether the responsible superiors were doing the supervision. On the other hand, a combined proportion of only 20% (10% - strongly agreed, 10%-agreed) were positive that supervision was on-going at their respective facilities of work. There have also been complaints of understaffing at all public health facilities. This is backed by Okwir (2009), who stated that in Uganda, the government has constructed health centers in almost every parish in addition to upgraded health centers with theatres at sub-county levels. But these lack health care workers and drugs to run them. This gives us a glimpse into the actual issues affecting the healthcare sector. Absence of support supervision could be a result of limited workforce in that,

those available are overloaded with work and can hardly get the time to follow-up on other people's work.

Table 6: Whether the Employer endeavors to train staff regarding the right to Health

Response	Frequency	Percent
Strongly Agree	20	50
Agree	8	20
Disagree	4	10
Strongly Disagree	8	20
Total	**40**	**100**

Source: *Field Interviews*

Training is an indispensable tool in management. It improves both skills and knowledge of the recipients. The findings indicated strong agreement among 50% (n=20) of the sampled health workers that staff are trained on matters regarding the right to health. Additionally, 20% (n=8) agreed to the same issue. However, a combined proportion of 30% (20%-strongly disagreed, 10%-diagree) indicated disagreement on this matter.

Table 7: Whether the Health Workers spend more than 8hours a Day at work

Response	Frequency	Percent
Strongly Agree	20	50
Agree	16	40
Disagree	4	10
Total	**40**	**100**

Source: *Field Interviews*

For over decades now, health workers especially in state owned health facilities complain of long working hours. The study established that this is true drawing from a considerable and combined proportion of 90% (50%-strongly agree, 40%-agree) of the sampled health workers who indicated that they spend more than 8 hours on job daily. However, they complain that regardless of their committed efforts to service, their effort is not commensurately rewarded. That brings us to the aspect motivation as presented next.

4.2.3 Motivation of Workers

Under this, the study considered remuneration of the health workers, recognition for outstanding performance, paid holidays and whether the employer provides free medical attention to staff that fall sick.

With regard to remuneration, an overwhelming proportion of 90% (n=38) indicated strong disagreement that the employer gives an attractive and sufficient remuneration to the health workers. Additionally, the remaining 10% (n=4) were also not sure whether the remuneration they are given is sufficient and this too indicates contradiction to the remuneration standards of the sampled facilities.

Table 8: Whether the employer Motivates workers who perform well as far as promotion of the right to health is concerned

Response	**Frequency**	**Percent**
Strongly Agree	4	10
Not Sure	12	30
Disagree	4	10
Strongly Disagree	20	50
Total	**40**	**100**

Source: *Field Interviews*

Motivation whether financial or non-financial is principal in stimulating creativity and productivity among employees. This is true in all circumstances regardless of the field and discipline or occupation. With regard to that, 50% (n=20) of the health workers strongly disagreed that the employer motivates workers who perform well as far as promotion of the right to health is concerned. Following that, 30% (n=12) of the sampled health workers said they were not sure as to whether the employer provides motivation for outstanding performers in observance of the right to health. Only 10% (n=4) indicated strong agreement that this was happening in their respective health facility.

4.2.4 Occupational Health and Safety

Under this, the study considered protection of workers with necessary gear, placing barriers appropriately so as to protect workers from dangerous harmful objects and material and lastly the treatment of employees. It is important to note that many organizations especially in the developing economies rarely consider occupational safety as a paramount area of interest in their establishments. This is not only true within the private sector but the public sector as well. However, several governments have been pressurized by the indigenous population through pressure groups and parliament to enact laws regarding occupational safety of workers. Occupational safety of workers is a health right and could directly influence the probability of health workers to observe the right to health of their patients. That is why organizations and companies have to place it up above in the hierarchy of priorities of their establishments.

Table 9: Whether the Health facility provides its Workers with Protective wear

Response	Frequency	Percent
Strongly Agree	4	10
Agree	16	40
Not Sure	4	10
Disagree	8	20
Strongly Disagree	8	20
Total	**40**	**100**

Source: *Field Interviews*

A combined proportion of 50% (40%-ageed, 10%-strongly agreed) indicated agreement to the statement that the health facility provides its workers with protective wear. However, a combined proportion of 40% (20%-Strongly disagreed, 20%-disgreed) indicated disagreement to this issue. Only 10% (n=4) of the respondents were not sure about the workers being equipped with protective gear while on duty. In light of these statistics, it appears that some health facilities do not have enough protective gear to facilitate their workers. This erodes their right to health and if the health worker is not protected, then it is highly likely that the patient's health rights will not be protected too.

Table 10: Whether the Health facility Provides Barriers to protect its workers from dangerous objects/sections

Response	Frequency	Percent
Strongly Agree	8	20
Agree	8	20
Not Sure	4	10
Disagree	4	10
Strongly Disagree	16	40
Total	**40**	**100**

Source: *Field Interviews*

Closely relating to the preceding aspect of protective gear, a combined proportion of 50% (40%-strongly disagreed, 10%-disagreed) indicated disagreement to the statement that suggested that the employer places barriers at the health facilities to protect workers from dangerous and harmful objects and materials. Only 20% (n-8) of the responding health workers strongly agreed followed by an equal proportion also 20% (n=8) who agreed. This makes a combined proportion of 40% of those who say there are barriers to protect workers from dangerous objects as compared to the 50% who say there are no such kinds of barriers for that purpose.

Table 11: Whether the Health facility Provides Medical care to its workers

Response	Frequency	Percent
Strongly Agree	8	20
Agree	16	40
Not Sure	4	10
Strongly Disagree	12	30
Total	**40**	**100**

Source: *Field Interviews*

On a positive note, a combined proportion of 60% (n=24 agree and strongly disagree combined) of the sampled health workers revealed that the health facilities provide free medical attention to their workers. Only 30% (n=12) disagree with this whereas only 10% (n=4) were not sure. It should be admitted that these statistics give a fairer picture of the observance of the right to health specifically for the health workers in government facilities.

Table 12: Whether there is Safe drinking water at the health facility

Response	Frequency	Percent
Strongly Agree	4	10
Agree	4	10
Not Sure	4	10
Disagree	4	10
Strongly Disagree	24	60
Total	**40**	**100**

Source: *Field Interviews*

It is embarrassingly, a combined proportion of 70% (60%-strongly disagreed, 10%-disagreed) revealed that they are not provided with safe drinking water at their facilities of work. Only 10% (n=4) strongly agreed backed by an equal percentage (10%) who also agreed that they have access to safe drinking water at their health facilities.

With such a big percentage (70%) of health workers failing to access safe drinking water at their workplace has a lot of implications to Uganda's observance of people's right to health of which the constitution gives the state mandate to observe. Indeed, a very large section of the patients said they do have access to safe water for drinking while at a health facility. This clearly indicates that where the health workers themselves are not catered for, the patients would absorb the same consequence. In line with the Social and Economic Objectives of the state as embedded in the Constitution of The Republic of Uganda, it was stated that:

> *"The State shall endeavor to fulfill the fundamental rights of all Ugandans to social justice and economic development and shall, in particular, ensure that all developmental efforts are directed at ensuring the minimum social and cultural well-being of the people; and all Ugandans enjoy rights and opportunities and access to education, health services, clean and safe water, work, decent shelter, adequate clothing, food security and pension and retirement benefits."*

On the other hand, unlike earlier constitutions that were silent on economic, social and cultural rights, the 1995 Constitution covers some of these rights. For example, it provides for the right to education, the right to a clean and healthy environment[39], women's rights[40], and minority rights. However, the

[39] Article 39
[40] Article 33

Constitution does not expressly provide for the right to health care. Because of this, some may argue that the right to health care is not justifiable in Uganda. Iain Byrne (2005) observed that non-codification of the right to health in domestic law is not necessarily a bar to its adjudication and enforcement by the courts. Byrne points out that the lack of constitutional protection for health rights provides courts, lawyers and activists with significant but not insurmountable challenges for enforcement.

Table 13: Whether there is a Clean and Safe Working Environment at the health facility

Response	**Frequency**	**Percent**
Strongly Agree	4	10
Agree	16	40
Not Sure	4	10
Disagree	4	10
Strongly Disagree	12	10
Total	**40**	**100**

Source: *Field Interviews*

For purposes of this study, clean and safe working environment translates to, among other factors; include clean toilets and bathrooms at the workplace. To these, a combined proportion of 50% (40%-agreed, 10%-strongly agreed) said were available while a combined proportion of 40% (30%-strongly disagreed, 10%-disagreed) were opposed to this. Only 10% (n=4) were not sure of the matter.

Table 14: Whether there is Safe Food at the Workplace

Response	Frequency	Percent
Agree	12	30
Not Sure	4	10
Strongly Disagree	24	60
Total	**40**	**100**

Source: *Field Interviews*

A majority of 60% (n=24) of the responding health workers indicated strong disagreement to accessibility to safe food at their workplaces. Only 30% (n=12) were positive about the issue by indicating their agreement to the issue. However, 10% (n=4) were not sure about the quality of food at their health facilities. Again, it would be self defeating to assume that patients would have access to safe food at a health facility when the health workers themselves are not.

Table 15: Whether there is Adequate Lighting at the Workplace

Response	Frequency	Percent
Strongly Agree	4	10
Agree	12	30
Not Sure	8	20
Disagree	8	20
Strongly Disagree	8	20
Total	**40**	**100**

Source: *Field Interviews*

The findings revealed a balance between the respondents who indicated agreement that there is adequate lighting at the workplace as compared to those

who indicated disagreement. Both stood at 40% each. However, 20% (n=8) were not sure whether lighting at their facilities was really adequate.

It should be noted that although there is no specific way to measure the amount of light for medical operations, the health worker should be able to tell whether their operating premises have adequate light to enable them execute their duties sufficiently.

According to IAPA (2009), proper workplace lighting is essential to any good business since it allows employees to comfortably see what they're doing, without straining their eyes or their bodies; it makes work easier and more productive; it draws attention to hazardous operations and equipment; and it helps prevent costly errors and accidents. All these are indispensable benefits to health workers in health facilities. IAPA (2009) adds that insufficient lighting also creates a dreary environment and can lead to visual fatigue and discomfort. It can also lead to neck and back pain, if the worker adopts a poor posture constant forward leaning in effort to see the work being done. All these affect not only the productivity but the moods of the workers.

Table 16: Whether there is Steady Water Supply at the Workplace

Response	Frequency	Percent
Agree	4	10
Not Sure	8	20
Disagree	20	50
Strongly Disagree	8	20
Total	**40**	**100**

Source: *Field Interviews*

Although The Constitution of the Republic of Uganda 1995 provides that every Ugandan is entitled to clean and safe water regardless of where they are located at a given time, only 10% (n=4) of the health workers agreed that they

have steady water supply at the workplace. The majority (50%-disagreed, 20%-strongly disagreed) indicated disagreement to the statement that there is steady water supply at their health facilities.

Drawing from the several definitions of occupational health and safety by organizations such as WHO and IL0 and national bodies and authorities, occupational health is considered to be multidisciplinary activity aiming at; protection and promotion of the health of workers by preventing and controlling occupational diseases and accidents and by eliminating occupational factors and conditions hazardous to health and safety at work; development and promotion of healthy and safe work, work environments and work organizations; enhancement of physical, mental and social well-being of workers and support for the development and maintenance of their working capacity, as well as professional and social development at work and enablement of workers to conduct socially and economically productive lives and to contribute positively to sustainable development. With the statistics as reflected in the presentation above, it can be deducted that the health facilities which were sampled are underscoring on all the issues mentioned in this summarized statement about what occupational health and safety is concerned with.

4.3 OBJECTIVE 2: LEVEL OF SATISFACTION OF PATIENTS IN RELATION TO THE RIGHT TO HEALTH

This formed the second objective of this study. It entailed determining the level of satisfaction of the patients derived from the health care services provided by the health facilities in light of the right to health. These are captured in the presentation that ensues:

Table 17: Whether the Health facility Provides Services Free of Charge

Response	Frequency	Percent
Strongly Agree	35	50
Agree	14	20
Not Sure	14	20
Strongly Disagree	7	10
Total	**70**	**100**

Source: *Field Interviews*

A combined large proportion of the patients indicated agreement (50%-strongly agreed, 20%-agreed) that they get free medical care services at the sampled public health facilities. Only 10% (n=7) were opposed to that view. In the same way, 90% (n=36) of the responding health workers said the health facilities were providing free medical services to the public without discrimination. By this, the Government of Uganda can be credited for the efforts. However, there were unverified reports from some of the patients that the public health facilities provide only cheap and simple treatments like paracetamol for the headaches, magnesium for stomach problems and dewormers, and that in case the patient needs more serious drugs, they are told to go and buy from the drug shops. This could not be taken literarily since the health workers themselves mentioned shortage of drugs in the health facilities. For that matter, the patients expressed strong dissatisfaction (80%) regarding the services at the respective health facilities in light of the right to health. Some patients have gone ahead to cite the saying that; *'free things are not free'* as way of expressing their dissatisfaction.

Table 18: Whether the Health facility Provides Services that help prevent diseases

Response	Frequency	Percent
Strongly Agree	42	60
Agree	14	20
Not Sure	7	10
Disagree	7	10
Total	**70**	**100**

Source: *Field Interviews*

The majority of the sampled patients (60%, n=42) indicated strong agreement that the services provided at the health facilities are preventive. This was followed by 20% (n=14) who in the same context indicated agreement to the same issue. However, 10% (n=7) were opposed to that while another proportion of 10% (n=7) were not sure. Drawing from literature, the broad definition of health implied by the right to health encompasses both the curative and preventive aspects of health. And that this dual focus corresponds with the distinctive perspectives of clinical medicine and public health, both of which have influenced how the right to health has been defined and evolved. For that matter, clinical medicine has traditionally focused on the health status of individuals while public health has focused on the need to promote and protect the health of populations and to ensure conditions under which people can be healthy and remain so. Precisely, the findings suggest that government does recognize and promotes the right to health through the public health facilities.

On the other hand, although patients recognized government's efforts through relevant institutions such as the parliament to enact laws and through ministries such as Ministry of health to develop programs to benefit the public,

the patients insisted that these were only good in words and on paper. They mentioned that several articles have been written in national news papers and that broadcasting media (radio and Television) have considerably reported on stolen drugs, poor treatment of the patients in referral hospitals and an alarming ratio of doctor to patient. For that matter, majority of the sampled patients (90%) expressed strong dissatisfaction to the observance of the right to health by government through the public health facilities.

Table 19: Whether the Health facility Provides Services that help cure diseases

Response	Frequency	Percent
Strongly Agree	49	70
Agree	21	30
Total	**70**	**100**

Source: *Field Interviews*

In comparison to the previous issue of the nature of services being offered by the public health facilities, the patients overwhelmingly agreed that the services are more of curative in nature. This is evidenced by 70% who indicated strong agreement and 30% who just agreed to the issue. The study further probed into whether the patients are consulted, kept informed and express their views regarding their health status. It was established that majority (80%) of the patients do not have fair grounds to express their views regarding making choice on the alternatives available as treatment for their sicknesses. It was revealed that most medical workers are used to dictating what works for the patients without explaining why, and without consulting and creating foundation for expression of views. However, when asked whether the treatment works, the majority of patients admitted that it does in most cases. This is similar to the example given by Wendo (2002) about an eight months pregnant mother who

had been induced for an emergency delivery, lay in the labor ward with no one telling her whether the baby was alive or not, neither did she know what kind of drugs the doctors were giving her. She had asked but the health workers refused, saying she was not a doctor and therefore would not understand the information'.[41]

Situations occasionally occur in which a patient suffers significant medical complications that may have resulted from the physician's mistake or judgment. In these situations, the physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred. Only through full disclosure is a patient able to make informed decisions regarding future medical care.

One survey found that virtually all of the patients desired some acknowledgment of even minor errors. For both moderate and severe mistakes, patients were significantly more likely to consider legal action if the physician did not disclose the error. Findings such as these reinforce the importance of open communication between physician and patient which in most cases is violated in developing economies like Uganda.

4.4 OBJECTIVE 3: THE EXTENT TO WHICH THE HEALTH FACILITIES IN KAMPALA OBSERVE THE RIGHT TO HEALTH

This formed the third and final objective of the study. It required a more qualitative and deductive approach based on available regulations. The Right-To-Health (RTH) Assessment tool was used in responding to this objective. This was used in addition to the level of satisfaction of both the health workers and the patients as presented in the previous two objectives.

The RTH assessment tool has five objectives but the study used only two which are applicable to this study and for Uganda's case. These steps include:

[41]Charles Wendo 27th August 2002(page 31) .

Step 1: Finding out the country's commitments by listing the standards you can hold your government accountable for instance if the government made a commitment under national or international laws.

According to Uganda's Health and Human Rights fact sheet, Uganda ratified a wide range of international and regional human rights treaties related to the enjoyment of the highest attainable standard of physical and mental health ('right to health')[42].

International commitments to human rights, including the right to health, provide a guiding framework for legislation, policies and programming at national level. This forms an important commitment by the government and it can be held accountable if it does not fulfill its mandate.

The Constitution of the Government of Uganda (1995) provides among its social and economic objectives that the State shall ensure that all Ugandans enjoy rights and opportunities and access to education, health services, clean and safe water, work, decent shelter, adequate clothing, and food, security, pension and retirement benefits. However, the right to health is not incorporated among the operational articles. The Constitution includes provisions against discrimination and provisions relating to specific groups, such as the rights of women, children, persons with disabilities and minorities. For that matter, the government of Uganda has to ensure that this gap is covered because it could be used to refer to the government as a non performer as far as the right to health is concerned.

Step 2: Whether Uganda's policies are appropriate to fulfill the obligations.

On a strategic note, Uganda's Poverty Eradication Action Plan (PEAP) 2004/5 – 2007/8 does not incorporate human rights as a cross-cutting issue. However, the PEAP states that the Government is committed to maintaining high standards of

[42] International Instruments to which Uganda is a party

human rights. The PEAP will be replaced by a five-year National Development Plan (NDP), which will outline overall policy objectives and development strategies. Partners have proposed that the plan incorporates a human rights-based approach in order to strengthen the focus on inclusion and accessibility for all.

The National Health Policy (NHP) 1999 and the Health Sector Strategic Plan II (HSSP II) 2005/2006 – 2009/2010 constitute a common strategic framework for all stakeholders. The Ministry of Health seems to have finalized the National Health Policy II and the Health Sector Strategic Plan III with the participation of health development partners and civil society organizations (CSOs), including human rights and gender equality advocacy groups. The NHP I and the HSSP II referred to rights in relation to specific health issues. The HSSP II also expressed a commitment to build individuals' and communities' awareness of their rights. Stakeholders have noted the importance of explicitly confirming Uganda's commitment to the right to health in the NHP II and the HSSP III and to ensure that strategic planning is guided by human rights standards and principles.

In recent years, the Government, health development partners and CSOs have taken steps towards integrating a human rights-based approach to health, resulting in important synergies. Human rights and gender focal points have been appointed in the Ministry of Health.

In September 2008, the Uganda Human Rights Commission (UHRC) officially launched its Right to Health Unit. The former Special Rapporteur on the right to health identified the UHRC as the national mechanism with "most promising possibilities" to monitor and ensure accountability of the implementation of the right to health in Uganda. The Unit has been operational since 2007 and has given specific focus to policies, programmes and projects relating to neglected tropical diseases. It has also supported trainings on a human rights-based approach for health professionals. The Right to Health Unit is mandated to monitor compliance by the Government of Uganda with the right

to health. The Unit operates under the UHRC's Monitoring and Inspections Directorate.

The International Covenant on Economic, Social and Cultural Rights requires states parties to create 'conditions which would assure to all medical attention in the event of sickness', including both physical and mental health (Article 12(2)(d)). In its General Comment 14, the ESCR Committee elaborates further on this right and finds that it includes the provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care. By signing international human rights treaties that affirm the right to health, a state agrees to be accountable to the international community, as well as its citizens, for the fulfillment of its obligations.

Uganda undertakes to honour treaty obligations and to this end endeavours to interpret the various articles contained in the covenant in good faith with a view to realising each covenant's objectives. This commitment is reiterated under principle xxviii of Uganda's foreign policy objectives enshrined in the Constitution.

Furthermore, the Uganda Constitution also imposes a general duty on the state to bring domestic laws into conformity with obligations under international law. However rules and obligations imposed by international law will not be binding on Uganda unless they are ratified and translated into national law. Hence, under article 123 (2) Parliament shall make laws to govern ratification of treaties, conventions agreement or other arrangements committing Uganda in the International sphere.

Furthermore, an important aspect is the improvement and furtherance of participation of the population in the provision of preventive and curative health services.

Considering the presentations under chapters one and two and in light of the above, government of Uganda has tried putting in place the necessary regulations to ensure that the right to health is observed. The government of Uganda constructed health centers in almost every parish in addition to upgraded health centers with theatres at sub-county levels. However, certain factors have played against the equal and full enjoyment of the right to health by all people in the country. For instance, literature links poverty to women's and men's vulnerability and inability to access social services such as health care. In a study of health care seeking and financing by households in Kabale and Iganga districts in Uganda, Lucas and Nuwagaba found that the poor have at times to borrow money to pay for health care. Twinomugisha (2007) also found that rural poor women in Kashambya Sub-county, Kabale District do not access and utilize maternal health care partly due to the inability to pay for the same. The PEAP also identifies poverty as one of the factors that inhibit vulnerable members of the household from accessing HIV/AIDS treatment and that the latter competes with other crucial expenditures such as food, shelter and educational expenses.

It should be noted that some of the literature views poverty simply as a matter of impoverishment. However, poverty is a multidimensional problem that goes beyond the traditional income approach or the failure to meet basic needs such as health care and is linked to disempowerment, dependency and oppression. This is true both in respect of the individual's ability to access health care and the state's capacity to provide for the same.

'..ill health is both a cause and a consequence of poverty: sick people are more likely to become poor and the poor are more vulnerable to disease and disability. Good health is central to creating and sustaining the capabilities that poor people need to escape poverty. A key asset of the poor, good health, contributes to their greater economic security. Good health is

not just an outcome of development: it is a way of achieving

development."[43]

The importance given to the "underlying determinants of health", that is, the factors and conditions which protect and promote the right to health beyond health services, goods and facilities, shows that the right to health is dependent on, and contributes to, the realization of many other human rights. These include the rights to food, to water, to an adequate standard of living, to adequate housing, to freedom from discrimination, to privacy, to access to information, to participation, and the right to benefit from scientific progress and its applications.

Conversely, individuals' right to health cannot be realized without realizing their other rights, the violations of which are at the root of poverty,

[43] Hunt P. E/CN.4/2003/58: paras 43 and 44.

such as the rights to work, food, housing and education, and the principle of non-discrimination.[44]

Human rights law places the primary responsibility to protect the right to health care on the state. But the available literature shows that globalization from above weakens the state's capacity to do so. It is thus necessary to analyze the root causes of poverty by interrogating the role of globalization in the struggle to realize economic, social and cultural rights such as the right to health care.

In addition to the current findings, literature too explains gender disparities existing in Uganda and how women have been short-changed and by-passed by the development process. Various analysts condemn the limited or low participation of women in decision-making processes. There is also an increased recognition that women's utilization and access to health care can only be effective when the underlying gender relations such as the sexual division of labour, and the access to and control of resources are addressed. It is also recognized that gender plays an integral role in determining an individual's vulnerability to infection, his or her ability to access care, support or treatment.

[44] Vienna Declaration and Programme of Action (A/CONF.157/23), adopted by the World Conference on Human Rights, held in Vienna, 14–25 June (1993).

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.0 Introduction

This chapter gives a summary of the major findings of the study from which conclusions are made. As with the summary section, one conclusion is made for each study objective. The chapter further presents recommendations which have been suggested to bridge the gaps identified within.

5.1 Summary

The organizational factors that affect the observance of the right to health include communication within the organization on issues regarding the right to health, management related aspects such as support supervision, motivation and welfare of workers and finally occupational safety of the workers.

The aspects of communication regarding the right to health were presence of documented rules, regulations and guidelines at the health facilities which 70% of the health workers said were available. The other communication aspect was whether the employer provides workers with information on the right to health to which 80% of the health workers said is happening.

Managerial issues that affect the observance of the right to health were considered as support supervision, which was found to be very inadequate (70%), training for health workers regarding the right to health which was said to be fairly observed by the employers (70%), motivation of workers through recognition of outstanding performance which was said to be inadequate (60%).

Finally, occupational health and safety of the health workers considered facilitating of workers with necessary protective gear which was said to be fairly observed (50%), provision of barriers for workers against dangerous objects

which was said to be inadequate (50%), provision of medical care to staffs, availability of adequate lighting at workplace, availability of safe water for drinking, safe food for staff, steady supply of clean and safe water and the length of time spent by staff working at the health facility.

An employer is required to take general protective measures including administrative and technical measures to prevent or reduce the contamination of the working environment.[45]

Every person has a right to a healthy environment and imposes a duty on every person to maintain and enhance the environment.[46]

Safe working environments protect the safety, health and welfare of people engaged in work or employment, and where work is carried out in or hazards spill into community may also protect co-workers, family members, employers, customers, suppliers, nearby communities, and other members of the public who are impacted by the workplace environment.

Every workplace must be kept in a clean state, free from effluvia arising from any drain, sanitary convenience and other nuisance; and must be in a healthy and safe working environment. Adequate sanitary conveniences must be provided at workplaces[47] .

It also requires adequate supply of wholesome drinking water and suitable points in a work place conveniently accessible to all workers.[48]

Only in Uganda does the Public Health Act provide for safe working environments, empowering the Minister to make rules for provision by employers of non domestic labour of hospital accommodation and medical attention, specifying the medicines, equipment and other requirements necessary.[49]

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[45] The Occupational Safety and Health Act (2006) (Section 95).
[46]The National Environment Act Cap 153 Section 3(1)(2).
[47]ibid (sections 46,47 and 49)
[48] Ibid
[49] Public Health Act (Section 118).

Healthy environments include access to health promoting shelter, water, sanitation, working conditions and community environments. Analysis of evidence from the East and Southern Africa region shows that socio-economic differentials in access to healthy environments are a determinant of inequalities in health, with particular disadvantage for poor communities.[50]

Uganda explicitly recognizes the right to a clean and healthy environment in the constitution. The right to clean and healthy environment was emphasized in[51] which granted, on behalf of non-smokers that smoking in public places was a violation of the right to a clean and healthy environment.

The patients' level of satisfaction from the health services provided at the health facilities was average. The patients derived satisfaction from receiving free treatment at the health facilities, receiving services that prevent diseases and receiving services that cure diseases. However, there were factors that led to patients' dissatisfaction such as absence of clean and safe water for drinking at the health facilities, long queues at the health facilities due to shortage in health personnel, limited supply of certain important drugs which are then bought from drug shops, non-communication by the health workers about the patients' health status and restricted involvement of patients expression of views on the treatment options available for certain illnesses.

Related cases to this are as for the deaths of Sylvia Nalubowa and Anguko Jennifer.

Constitutional Court Case Number 16 of 2011, a landmark case arguing that, by not ensuring that the health sector provides the lifesaving essential

[50] EQUINET SC, 2007
[51] The Environmental Action Network Ltd V The Attorney- General National Environment Management Authority (NEMA) (Misc. Application No. 39 of 2001);

medicines, trained health workers, family planning commodities, emergency obstetric services, HIV treatment, malaria prevention and treatment, and other critical maternal health care services, the Government of Uganda is violating the Constitutional enshrined right to health and life. The petition is a case in which Civil Society Organizations working in the health sector have petitioned the constitutional court to declare that the avoidable deaths of women in the process of childbirth constitutes abuse of their right to health.[52] The petition further argues that by not providing essential medical commodities and health services to pregnant women, the government is violating the constitutional rights of Ugandans.

Pregnancy and childbirth should be a cause for celebration and fulfillment. However, on a daily basis, 16 women die in childbirth making their pregnancy experience a time for tears and mourning rather than joy and continuously perpetuating poverty and misery for families. The court case highlights the case of Sylvia Nalubowa of Mityana and Jennifer Anguko of Arua. The death of Mbale teacher Cecilia Namboozo is the current shadow of grief for us all.

Another related case is the case of Nafuna. Courts have maintained that even in situations like Uganda where health centers are poorly serviced, in terms of medicines and medical equipment, a doctor or any other health worker has a higher duty to provide a satisfactory standard of care to avoid causing injury to a patient like the case was with Nafuna a baby girl who lost her arm due to a poorly administered injection. Further, the girl's father didn't consent to decision of the specialist doctor to amputate her arm which led to permanent disability.

Female Genital Mutilation also constitutes a clear violation of human rights and the participation of healthcare workers in the procedure would legitimate this cruel and harmful practice.[53]

[52] Constitutional Court Case Number 16 of 2011
[53] Appendix V111

In Uganda, the National Health Policy requires government to develop mechanisms to ensure equity in access to basic services to avert pregnancy and birth related deaths and the childhood killer diseases.

While health information and education is fundamental for people to promote and protect health, it is poorly embodied in law, with weak provision for rights to sufficient health education and information to ensure that health decisions are informed.

Uganda has constitutional provisions to provide for access to health services.

The extent to which the public health facilities in Kampala observe the Right to Health under International Law was determined by using the Right-To-Health (RTH) tool of whose five objectives only two were adopted. These were; listing out the commitments made by Uganda by ratifying for instance the treaties and/or instruments of law spelling out the issues regarding the Right to Health on the international, regional and national levels.

Besides the Constitution of 1995, Uganda has consented to several international and regional human rights treaties related to the enjoyment of the highest attainable standard of physical and mental health ('right to health'), including the ICESCR, CEDAW, CRC and ACHPR. From these International commitments to human rights, including the right to health, the government of Uganda has a guiding framework for legislation, policies and programming at national level.

The second step of RTH was adopted to show whether Uganda's policies are appropriate to fulfill the obligations. The most important of the policies in place included Uganda's PEAP 2004/5 –2007/8 which although does not incorporate human rights as a cross-cutting issue, states that the Government's commitment to maintaining high standards of human rights.

The other policy was the NHP 1999 and the HSSP II 2005/2006 – 2009/2010 which constitute a common strategic framework for all stakeholders.

The Ministry of Health was also said to have finalized the NHP II and the HSSSP III with the participation of health development partners and civil society organizations (CSOs), including human rights and gender equality advocacy groups. These form part of the policy framework which the government is using to achieve and fulfill the commitments it made by ratifying the treaties indicated as above.

5.2 Conclusion

The organizational factors affecting the observance of the right to health have a big influence, ranking next to the government policies and programmes developed to achieve the right to health. The implementing teams need to be utilized sufficiently and adequately facilitated to ensure that health facilities observe and promote the right to health.

The nature and status of the welfare of health workers in health facilities have a considerable bearing on the level of satisfaction of the patients who seek for medical attention from the public health facilities. In precise terms, both people (health workers and their patients) are entitled to the right to health and the fulfillment of the right to health for the health workers could support fulfilling the right to health of the patients in some way.

By signing treaties and ratifying the different instruments of law at national, regional and international levels, the Government of Uganda can be held responsible for promoting and protecting the Right to Health of its citizens. The action of ratifying the said instruments amounts to commitment to fulfill the provisions of the instruments. It also forms an integral step towards achieving the Right to Health in the country of the consenting government. Given the fair balance of policies as shown in the summary in line with the right to health, the health facilities in Kampala being under government are fairly contributing to the

achievement of the Right to Health despite the shocks caused by certain unpleasant happenings such as corruption.

Furthermore, the Uganda Constitution also imposes a general duty on the state to bring domestic laws into conformity with obligations under international law. However rules and obligations imposed by international law will not be binding on Uganda unless they are ratified and translated into national law. Hence, under article 123 (2) Parliament shall make laws to govern ratification of treaties, conventions agreement or other arrangements committing Uganda in the International sphere.

5.3 Recommendations

Management at health facilities should engage the health workers in the decision making process as the health workers are directly knowledgeable about and are part of the factors that determine the observance of the right to health for the patients.

Monitoring the Right to Health is the participation of health professionals in the protection and promotion of health-related human rights by applying their medical skills and providing medical data. Doctors and nurses can document inequalities in access to health care, clean water and sanitation due to poverty and/or discrimination.[54]

Additionally, the health workers are vehicles by which the right to health of the patients at the health facilities can be realized. This means that the status of welfare and personal development of the health workers requires special consideration in the planning process.

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[54] International Federation of Health and Human Rights Organizations (IFHHRO) 2009.

There should be deliberate efforts directed towards sensitizing patients about what encompasses their right to health. Some of the patients could have received better treatment if they were aware of their rights to health.

In terms of policy, the government of Uganda has done a fairly credible work towards promoting and protecting the right to health of individuals and groups. Nevertheless, there is need to take keen interest in *'developing water tight"* procedures and strengthening of the systems and structures meant to safeguard the resources set aside for promoting the right to health. This is essential to deal away with corrupt practices of stealing of drugs from public hospitals which could be partly responsible for the shortage, embezzlement and misappropriation of monies for certain activities at health facilities' level.

In terms of implementing the law, there are opportunities for improved interaction across institutions, such as:

1) strengthening interaction between health and education services and stimulating shared mandates, such as in promotion of Primary Health Care;
2) strengthening coordination between central and local government and other institutions, including private sector and non governmental entities working in health;
3) strengthening the capacity of regulatory agencies and professional regulatory bodies established under the law in terms of their operations, technical knowledge and expertise, reporting and accountability, infrastructure and equipment, financial resources, number and skills of staff;
4) providing public information on existing policies and laws;
5) strengthening access to courts by vulnerable groups by creating more awareness of the existence of the rights and the available avenues for redress in case of breach; and
6) legal training in public health to increase competencies in the courts to manage public health cases.

Improved practice could also be stimulated by ensuring wider public debate and input to laws when they are under development, adequate operational guidelines for laws and regulations after they are enacted and improved health literacy on legal provisions for the public through mass media and civil society.

Widen the current focus in public health laws on primary *medical* care and infectious disease control to cover primary health care and its elements.

7) Strengthen laws governing private health providers in terms of their co-ordination, requirements for service provisioning, principles covering practice, reporting obligations and the government authorities and public rights to information, consultation and participation in relation to these services. This includes traditional health practice.
8) Updating public health law to include provisions for public information, awareness and participation such as those in more recent laws such as those around HIV and AIDS.
9) Setting out roles, authorities and mechanisms for public participation in health services and for public accountability of health services. This includes providing mechanisms for direct community participation in running health services and for inter-sectoral co-operation and co-ordination, and data and reporting obligations of public and private health services.

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APPENDIX 1A

KAMPALA INTERNATIONAL UNIVERSITY

QUESTIONAIRE FOR PATIENTS/ HEALTH SERVICES CONSUMERS

Dear respondent,

It's an honor that you are going to contribute to this academic study being conducted on **'Uganda's compliance with the right to health in selected health facilities in Kampala'**. In your position as a patient you have useful information to contribute to the success of the study. Please answer the questions to the best of your knowledge. The information you give shall be treated as confidential and shall be purely for academic purposes.

SECTION A: BIO DATA

Please tick or circle the Applicable and Appropriate option.

A1. Gender of respondent

Male ☐ Female ☐

A2. Marital Status

Married ☐ Never married ☐ Divorced ☐ Widow ☐

Widowed ☐

A3. Age of respondent

20-29 years ☐ 30 - 39 years ☐ 40 - 49 years ☐ above 50 ☐

A4. Level of education

Certificate ☐ Diploma ☐ Bachelor's Degree ☐ Masters degree ☐

Others, specify.....

A5. How often do you use healthcare services?

Every month ☐ within three months ☐ Once in six months ☐

Once in a year ☐

Please indicate your agreement or disagreement with the following statements by ticking in the columns marked by the numbers described in the key below accordingly:

Strongly agree	**Agree**	**I am not sure**	**Disagree**	**Strongly disagree**
1	**2**	**3**	**4**	**5**

A6: My healthcare provider provides special services for:	1	2	3	4	
Persons with disabilities					
The children					
Women during pregnancy and after delivery					
People living with HIV/AIDS					
Refugees					
The elderly patients					

A8: Services provided by the healthcare system	1	2	3	4	5
1. Safe drinking water is always provided at the health facilities					
2. There are Clean toilets at the health facilities					
3. The health facility is in a dump environment					
4. There is adequate lighting at the health facilities					
5. There is a steady supply of water at the health facilities					
6. The health facility is in a contaminated environment					
7. I participate in decision making for the good of the service					
8. Services are free of charge					

9. Services are affordable					

SATISFIERS AND DISSATISFIERS	1	2	3	4	5
10. The doctors/ health workers provide me with opportunities to express views about the health care system in Uganda					
11. The doctors/ health workers keep me informed about my health condition/ status					
12. I feel fairly satisfied with the health system in the country					
13. I feel loyalty of healthcare workers towards their work					
14. I am generally satisfied with the country's health care policies					
15. I am satisfied with the governments involvement in health sector					
16. Services provided help in diseases prevention					
17. Services provided help in treating diseases					

Thank you for your cooperation.

TUMWEBAZE JULIETH, LLM/43088/92/DU

APPENDIX 1B

KAMPALA INTERNATIONAL UNIVERSITY

QUESTIONAIRE FOR HEALTHCARE WORKERS

Dear respondent,

It's an honor that you are going to contribute to this academic study being conducted on **'Uganda's compliance with the right to health in selected health facilities in Kampala'.** In your position as an opinion leader/ policy maker you have useful information to contribute to the success of the study. Please answer the questions to the best of your knowledge. The information you give shall be treated as confidential and shall be purely for academic purposes.

SECTION A: BIO DATA

Please tick or circle

B1. Gender of respondent

Male ☐ Female ☐

B2. Marital Status

Married ☐ Never married ☐ Divorced ☐ Widow ☐
Widowed ☐

B3. Age of respondent

20-29 years ☐ 30 - 39 years ☐ 40 - 49 years ☐ above 50 ☐

B4. Level of education

Certificate ☐ Diploma ☐ Bachelor's Degree ☐ Masters degree ☐
Others, specify.....

B5: How long have you been in the health sector?

1) 1-5 years ☐
2) 5 -10 years ☐
3) 10-15 years ☐
4) 15 – 20years ☐
5) 20 – 25 years ☐
6) 26 and above ☐

B6: Are you satisfied with the health systems in Uganda?

Yes ☐ No ☐

B7.1: If yes, how does the system meet the Right to Health as a fundamental human right?.....

.....

.....

B8: If No, how does the system hinder the achievement of the Right to health in Uganda?

.....

.....

.....

B9: What has your hospital/ health centre/ care institution put in place to ensure the right to health of all Ugandan citizens?

.....

.....

.....

.....

Please indicate your agreement or disagreement with the following statements by ticking in the columns marked by the numbers described in the key below accordingly.

Strongly agree	**Agree**	**I am not sure**	**Disagree**	**Strongly disagree**
1	**2**	**3**	**4**	**5**

B10: My healthcare system provides special services for:	1	2	3	4	5
Persons with disabilities					
The children					
Women during pregnancy and after delivery					
People living with HIV/AIDS					
Refugees					
The elderly patients					

B11: Services provided by the healthcare system	1	2	3	4	5
1. Safe drinking water is provided at the work place					
2. There are Clean toilets at my work place					
3. My working environment is very clean					
4. I have access to Safe food when at work					
5. I work in a Healthy environment					
6. I work in a dump environment					
7. There is adequate lighting at my work place					
8. There is a steady supply of water at my work place					
9. I work in a contaminated environment					

10. I work more than eight hours a day					
11. I participate in decision making for the good of the service					
12. Services are free of charge					
13. Services are affordable					
14. Services are preventive					
15. Services are curative					

B12: Organization's performance	1	2	3	4	5
1. This institution has some written rules, regulations and guidelines regarding the right to health.					
2. The employer provides trainings for workers in the right of patients.					
3. The employer provides necessary information on the right to health.					
4. The employer provides medical care for all the workers in case they get sick or injured.					
5. The employer provides sufficient protective gears					
6. The employer provides barriers to dangerous objects.					
7. The employer motivates workers who perform well as far as the promotion of the right to health is concerned.					
8. The employer usually supervises work.					
9. The employer demands for medical examination of workers before they join the organization.					
10. Sick workers are always given paid holidays for treatment.					

APPENDIX 1C: DATA COLLECTION CHECKLIST

- ☑ International conventions and Human Rights Treaties on the right to health
- ☑ Uganda's Government position on the right to health
- ☑ Public Health facilities and how they treat their employees regarding the right to health
- ☑ Public Health facilities and how their health staffs manage patients
- ☑ Public Health staff motivation strategies in health facilities
- ☑ Public Employees' satisfaction with the service they get from the health facilities
- ☑ Occupational health and safety within the Public health facilities
- ☑ Kinds of health services provided by the Public health facilities
- ☑ Patients' concerns on the quality of healthcare services they receive from the Public health facilities
- ☑ Health Staff views on the situation of health care in Uganda
- ☑ Health Staff views on the situation of health care in Uganda
- ☑ Accessibility and affordability of the healthcare services provided in Public health facilities

Documents

- ☑ The Constitution of the Republic of Uganda and the Right to health
- ☑ National Development Plan
- ☑ National Health Policy
- ☑ Health Sector Strategic Plan (HSSP II)
- ☑ Poverty Eradication Action Plan 2004/05 – 2007/08.
- ☑ Fact Sheet on Human Rights in Uganda

APPENDIX 11

Constitutional Court Case Number 16 of 2011

On the 27th of May 2011 the Centre for Health Human Rights and Development (CEHURD), a Ugandan NGO, and the families of two mothers who died in government hospitals in 2009 in Uganda approached the Ugandan Constitutional Court alleging the women's deaths were caused as a direct result of Uganda's failing healthcare system. Sylvia Nalubowa in Mityana and Anguko Jennifer in Arua died as a result of the government's failure to fulfill its constitutional obligations to provide basic maternal healthcare to expectant mothers. The petitioners urge the Court to declare that the continuous failure to implement effective policies on maternal healthcare, under-staffing, and the non-availability of basic maternal commodities in government hospitals amount to violations of pregnant women's rights to health and life.

The petitioners argue that the tragic deaths of Sylvia Nalubowa and Anguko Jennifer are but two manifestations of a larger problem of an unacceptably high rate of maternal mortality in Uganda. They hope that a declaration to this effect by the Court will force the Ugandan government to increase its budget for maternal healthcare. In addition the petitioners seek compensation for the families of the Sylvia Nalubowa and Anguko Jennifer.

APPENDIX 111

Female genital mutilation

Female genital mutilation (FGM) is a collective term used for a range of practices involving the removal or alteration of parts of healthy female genitalia. FGM can be an extremely painful procedure with both immediate and long term health risks, including haemorrhage, tetanus, septicaemia and even death. The practice of FGM clearly violates a woman's right to health. It can cause long-term sexual and reproductive problems and has been shown to increase mortality during childbirth. FGM is typically performed on girls between 4 and 15, although it is sometimes carried out on new babies and women prior to marriage. The procedure is often performed in unsterile conditions without anaesthesia.
It is sometimes argued that, as it would minimise some of the health risks, FGM should be performed by doctors in sterile conditions with anaesthesia. The practice constitutes a clear violation of human rights and the participation of healthcare workers in the procedure would legitimate this cruel and harmful practice.

APPENDIX 1V

THE COSTITUTION OF THE REPUBLIC OF UGANDA 1995

(RELEVANT ARTICLES)

NATIONAL OBJECTIVES AND DIRECTIVE PRINCINPLES OF STATE POLICY

Protection and Promotion of Fundamental and other Human Rights and Freedoms.

V. Fundamental and Other Human Rights and Freedoms

(i) The State shall guarantee and respect institutions which are charged by the State with responsibility for protecting and promoting hurnan rights by providing them with adequate resources to function effectively.

(ii) The State shall guarantee and respect the independence of non-governmental organisations which protect and promote human rights.

Social and Economic Objectives.

XIV. General Social and Economic Objectives.

The State shall endeavour to fulfil the fundamental rights of all Ugandans to social justice and economic development and shall, in particular, ensure that-

(i) all developmental efforts are directed at ensuring the manimum social and cultural well-being of the people; and

(ii) all Ugandans enjoy rights and opportunities and access to education, health services, clean and safe water, work. decent shelter, adequate clothing, food security and pension and retirement benefits.

XX. Medical Services.

The State shall take all practical measures to ensure the provision of basic medical services to the population.

XXI. Clean and Safe Water.

The State shall take all practical measures to promote a good water management system at all levels.

XXII. Food Security and Nutrition

The State shall-

(i) take appropriate steps to encourage people to grow and store adequate food;

(ii) establish national food reserves; and

(iii) encourage and promote proper nutrition through mass education and other appropriate means in order to build a healthy State.

The **Constitution** provides that: all persons are equal before and under the law in all spheres of political, economic, social and cultural life and in every other respect and shall enjoy equal protection of the law (Article 21(1)); and a person should not be discriminated against on the ground of sex, race, colour, ethnic origin, tribe, birth, creed or religion, social or economic standing, political opinion or disability (Article 21(2)). It empowers Parliament to make laws to implement policies and programmes to redress social, economic, educational or other imbalance in society (Article 21(4)).

Right to a clean and healthy environment.

39. Every Ugandan has a right to a clean and healthy environment.