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CELEBRATING THE CENTER FOR HEALTH, HUMAN RIGHTS AND DEVELOPMENT (CEHURD), A TEN YEAR OLD ADULT

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KEY NOTE ADDRESS

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Abstract

*Ten years in the life of a human rights organization is nearly a lifetime, a fact which is particularly true in the case of organizations in developing country contexts such as Uganda. Consequently, the 10th anniversary celebration of the Centre for Health, Human Rights and Development (CEHURD) should not be taken for granted. This is especially true given its pioneering work in the rather neglected area of promoting and protecting the right to health (RTH). At 10, CEHURD is a paragon of the 3Vs: a **V**ibrant, **V**ivacious and **V**igourous organization offering scholars and practitioners numerous points of reflection on the efficacy of protecting economic, social and cultural rights (ESCRs), against the backdrop of retreating state obligations, the onslaught of neoliberal economic policies and dealing with a judicial system only grudgingly accepting the justiciability of this often-neglected category of human rights.*

I. INTRODUCTION: THE MYSTERIOUS PARADOX OF THE TEN-YEAR OLD ADULT

Ten years in the life of a human being is not a very long period of time. Indeed, one would just be entering adolescence as they embark on the life of a teenager. On the other hand, ten years in the life of an organization is nearly a lifetime, a fact which is particularly true in the case of organizations in developing country contexts such as Uganda. Many have the stories been told of organizations that fail to hit the five-year mark. Several are lucky if they even make two. But there are also many 10-year old organizations that exist only on

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* A version of this paper was given as a keynote address at the 10th Anniversary of CEHURD on November 7, 2019 by Prof. J. Oloka-Onyango.
CEHURD has been the leading advocate for health rights in Uganda and has been a litigant in a number of landmark rulings incidental to the right to health. Its ten year anniversary is a landmark occasion and a cause for serious reflection of the journey for health rights hitherto and their future in the next decade.

life-support; such organizations are clinically dead and should be accorded a decent burial.

The Centre for Health, Human Rights and Development (CEHURD) at 10 is a paragon of the 3Vs: it is **V**ibrant, **V**ivacious and **V**igourous. It is very much alive and extremely accomplished. Even though I don't have an MB.ChB, I can safely declare that CEHURD's systolic and diastolic blood pressure readings are perfect; it has no chronic diseases and its prognosis is excellent! Moreover, CEHURD is marking this accomplishment as we enter the 3rd decade of the 21st century – a time when so much change and development is taking place all around the world. CEHURD is matching the pace. Consequently, we have a lot to celebrate at this 10-year anniversary of the organization.

But we also have a lot to critically reflect on as a result of the work that CEHURD has done and still intends to carry out. Thus the title "Celebrating CEHURD, the mysterious paradox of the 10-year old adult." On its website, CEHURD describes itself as**:** a non-profit, research and advocacy organization which is pioneering the justiciability of the right to health. The vision of the organization is: "Social Justice in health." Its four main areas of focus or mission are**:**

SOCIAL JUSTICE, EMPOWERMENT, HEALTH RIGHTS and LITIGATION.

Drawing from its full name, it is clear that CEHURD is devoted to three general areas of activist concern, *viz.*, Health, Human Rights and the broader quest for Development, and I want to talk about each of them and why they are of considerable relevance to Ugandans at large. In talking about them I will highlight both CEHURD's contribution to these issues as well as touch on broader questions of conceptualization, strategy, and politics.

Health, human rights and development are relevant for three main reasons:

(1) Health is important because Ugandans are suffering from a situation of collective and extended (but undiagnosed) post-traumatic stress disorder (PTSD), alongside a host of other mental and physical ailments. As the doctors will tell you, PTSD is a mental health condition triggered by either experiencing

or witnessing a terrifying event. Over the 57 years of our independence we have collectively experienced and jointly borne witness to so many terrifying events, including military *coups d'etat*, armed conflict, extensive sexual – and gender-based violence (SGBV), police brutality, life-term and age-limitless dictatorships and a variety of other calamities, human and natural. However, we have failed to receive adequate treatment for them. That lack of treatment partly explains the numerous social, political, economic and health problems that we today experience as a country.

(2) <u>Human rights</u> are important not so much because we recognize them in international instruments and in our Constitution, but because despite that recognition they continue to be violated. Moreover, the violation of human rights is not only by the State or the government. It is violations in the family, by the community, and by our most cherished institutions – educational, religious and social. It is also violations by supra-national and international organizations, including (and especially) transnational corporations (TNCs).

(3) <u>Development</u> is important because few other countries in Africa or elsewhere around the world have so embraced the Gospel of neo-liberal economics (NLE) as we have done in Uganda.[1] At core in Uganda's NLE is the privatization of public social services deregulation, reduced overall public funding and donor-dominated fiscal and economic planning. Ultimately, neoliberalism places an emphasis on individual accomplishment and capacity as opposed to the social protection of the community.[2] Consequently, the state abandoned measures designed to buffer the community from the vagaries of social upheaval or economic collapse. Today, there is nothing in Uganda which is not for sale; nothing is sacred. In short, Uganda sold its soul to the devil. In

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1 See Jörg Wiegratz, Giuliano Martiniello and Elisa Grecon, "Introduction: Interpreting change in neoliberal Uganda," in Jörg Wiegratz, Giuliano Martiniello and Elisa Grecon, *Uganda: The Dynamics of Neoliberal Transformation*, London: Zed Books, 2018.

2 Sarah N. Ssali, "Neoliberal health reforms and citizenship in Uganda," in Wiegratz, *et al*, *ibid*, at 179.

this case the devil is the market, which has been extolled as the key which will open every door, even the door to better healthcare.

However, let us not forget the Gospel according to Mark Chapter 8, verse 36: *What good is it for someone to gain the whole world, yet forfeit their soul*? Uganda may have gained the world – indeed recent statistics from UBOS disclose that we are much richer as a country and individually than previously thought.[3] However, we have lost our soul in the extremes of economic inequality and material impoverishment for those at the lower end of the social hierarchy. That loss of soul has resulted in a combination of acute poverty, powerlessness and social exclusion, and in specific relation to the health sector, to elite control, urban-bias and economic incapacity.[4]

The scourge of PTSD, human rights violations and neo-liberalism helps us understand why the work of organizations such as CEHURD in promoting, protecting and fully implementing our varied human rights is so important. These ailments have had a particularly negative effect on our attempt to achieve the realization of the right to health. Unless we find a cure for our collective PTSD and address the trauma imposed on us by neo-liberalism Ugandans shall continue to have problems with the realization of the right to health. My message is therefore quite simple: we need to more effectively and comprehensively address the promotion and protection of marginalized rights such as the right to health, just as we challenge the highly deleterious effects of neo-liberalism. Otherwise, we are condemning a considerable section of our people to living only a partial and incomplete human existence.

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[3] According to a recent report in the Observer, "Taking the 2018/19 figure ($33bn) for instance, it means that each Ugandan now is estimated to earn $891 or Shs 3.1m annually, up from $860 the previous year." See URN, "Ugandans Richer than previously thought," *The Observer*, October 11, 2019, at: https://observer.ug/news/headlines/62267-ugandans-richer-than-previously-thought-ubos

[4] Ssali, *op.cit.*, at 196.

II. THE RIGHT TO HEALTH AND ITS REALIZATION TODAY

International and regional law enshrines several provisions definitions on the right to health, ranging from Article 25 of the Universal Declaration of Human Rights, Article 12 of the ICESCR; several provisions of the Convention on the rights of the Child (CRC); Article 28 of the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families; Articles 12 and 14 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW); Articles 16 and 18 of the African Charter of Human and Peoples' Rights, Article 25 of the Convention on the Rights of Persons with Disabilities, as well as numerous provisions of the protocol to the African Charter of Human and Peoples' Rights on the Rights of Women in Africa, better known as the "Maputo Protocol." The policy environment has further recently been influenced by the Millennium Development Goals (MDGs) of 2000, which were followed by the Sustainable Development Goals (SDGs) formulated in 2012. Both contain several goals of critical relevance to the realization of the right to health.[5] At the national level there is the National Development Plan (NDP), now reaching the end of its second phase.[6] Even more targeted are the numerous plans released by the

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5 MDGs relevant to the realization of the right to health included: 1 (eradicate extreme poverty and hunger); 3 (promote gender equality and empower women); 4 (Reduce child mortality); 5 (improve maternal health), and 6 (combat HIV/AIDS, malaria and other diseases. For SDGs these include nos. 1 (No poverty); 2 (No hunger); 3 (Good health); 4 (Quality education); 5 (Gender equality); 6 (Clean water and sanitation), and 10 (Reduced inequalities). See UNDP, *Final Millennium Development Goals Report for Uganda 2015: Results, Reflections and the Way Forward*, https://www.ug.undp.org/content/uganda/en/home/library/mdg/final-millennium-development-goals-report-for-uganda-2015.html, and UNDP, *Roadmap for creating an enabling environment for delivering on SDGs in Uganda*, October 26, 2018, at:https://www.ug.undp.org/content/uganda/en/home/library/human_development/Roadmap_for_creating_an_enabling_environment_for_delivering_on_SDGs_in_Uganda.html.

6 NPDII has prioritized five key growth drivers with the greatest multiplier effect as identified in the *Uganda Vision 2040* namely: Agriculture; Tourism; Minerals, Oil and Gas; Infrastructure; and Human Capital Development.
See: http://www.npa.go.ug/development-plans/national-development-plan-ndp/.

Ministry of Health, although the extent to which these are rights-sensitive is debatable.[7]

Although, there is no express right to health in the Bill of Rights of the1995 Constitution, it is quite clear that it is not only a right, but that it is justiciable.[8] I mention the word "justiciable" because there is some debate about whether – on account of the location of the right to health in the National Objectives and Directive Principles of State Policy (NODPSP)—such rights can be the subject of judicial enforcement.[9] Indeed, one of CEHURD's main goals is to pioneer the justiciability of the right to health. At the 6th Annual Economic, Social and Cultural Rights Conference held at Makerere in September, this issue was of such prominence that participants called for a "new" Chapter Four which would comprehensively include ESCR rights such as the right to shelter/housing, food, health and water and move them out of the NODPSP.[10]

For the avoidance of doubt, and even though I was an early proponent of the same view,[11] it is now my considered opinion not only that the many economic and social rights in the NODPSP are justiciable, but also that this issue is now

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7 https://health.go.ug/publications/strategic-plans.

8 See Ben Kiromba Twinomugisha, *Fundamentals of Health Law in Uganda*, Pretoria: PULP, 2015, at 27-29.

9 Robinah Kaitiritmba, Moses Kirigwajjo, Aloysius Ssennyonjo & "The Right to Health in Uganda: Implications and Practical Steps to Achieving Universal Health Coverage," in Freddie Ssengooba, Suzanne N. Kiwanuka, Elizeus Rutebemberwa & Elizabeth Ekirapa-Kiracho (eds.), *Universal Health Coverage in Uganda: Looking Back and Forward to Speed Up the Progress*, Kampala: MUSPH, 2018 at 110.

10 This has been a long-standing demand of human rights groups in Uganda, among others articulated at the most recent universal peer review (UPR) process at the UN Human Rights Council, Working Group on the Universal Periodic Review Twenty-sixth session 31 October-11 November 2016: Uganda, A/HRC/WG.6/26/UGA/3; para.22, at: https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/187/38/PDF/G1618738.pdf?OpenElement. See also Initiative for Social & Economic Rights (ISER), *Meaningful Access to Justice for Economic and Social Rights*, https://www.iser-uganda.org/images/downloads/meaningful_access_to_justice_for_ESRs.pdf.

11 J. Oloka-Onyango, *Economic and Social Human Rights in the Aftermath of Uganda's Fourth Constitution: A Critical Reconceptualization*, CBR Working Paper No.88/2004.

beyond debate.[12] Indeed, CEHURD's main contribution has been to ensure the full justiciability of the right to health by filing its landmark case on the issue of maternal health care.[13] Many of you will remember that the Constitutional Court initially attempted to run away from this issue by proclaiming the matter to be a "political question" beyond court adjudication.[14] However, the Supreme Court appeal decision left no doubt over the issue.[15] Chief Justice Bart Katureebe was unequivocal in declaring that, "… there is no matter done by the Executive or by the Legislature which may not be a subject of judicial review if it is not done in accordance with the provisions of the Constitution."[16] What this means in effect is that all the provisions in the NODPSP can be the subject of court adjudication.

Furthermore, through a creative reading of the right to life provision which is a foundational element of the Bill of Rights, many of the socioeconomic rights that are in the NODPSP can be given enforcement.[17] Countries like India, Nepal and Nigeria have creatively used these provisions even where they have been declared *non*-justiciable in the Constitution. Relatedly, other rights can also be invoked in order to protect the right to health, including, freedom from torture, the protection of bodily integrity and of human dignity. In short, there is no need for a revision of Chapter Four. Let us concentrate our efforts in this respect on forcing the Judiciary to abandon its lackadaisical approach to

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12 Article 8A, 1995 Constitution

13 *CEHURD and Others v Attorney General of Uganda*, [Constitutional Petition No.16 of 2011].

14 See ISER, *A Political Question? Reflecting on the Constitutional Court's Ruling in the Maternal Mortality Case (CEHURD and Others v Attorney General of Uganda*, https://www.iser-uganda.org/images/downloads/ISER_Commentary_maternal_mortality_case.pdf.

15 See *CEHURD and Others v Attorney General of Uganda*, [Constitutional Appeal No.13 of 2013], at 19-20, accessed at: https://www.escr-net.org/sites/default/files/caselaw/cehurd_and_others_v_attorney_general.pdf.

16 *Ibid.,* judgment of Chief Justice Bart Katureebe.

17 See Berihun Adugna Gebeye, "The Potential Role of Directive Principles of State Policies for Transformative Constitutionalism in Africa," *Africa Journal of Comparative Constitutional Law*, Vol.1, No.1 (2017): 1-34, esp. 29-33.

enforcing the rights in the NODPSP and becoming much more pro-active on them.[18]

Thus, what we should instead be debating is the *content* of the right to health and the appropriate mechanisms for its enforcement. Objective XX of the NODPSP states, "The state shall take all practical measures to ensure the provision of basic medical services to the population." This provision very clearly points to the most essential element of the right to health. However, one can also add on Objectives V (adequate resources for institutions protecting and promoting human rights); VII (the aged); XIV (omnibus clause on health services); XVI (PWDs); XIX (protection of the family), XXI (clean and safe water) and XXII (Food security and nutrition). Indeed, the broadness of this last provision, stipulating the mandatory obligation that the State *shall*, "… (c) encourage and promote proper nutrition through mass education and *other appropriate means* in order to build a *healthy* State" opens up numerous possibilities for social action in achieving this goal.

In my view, the human right to health means that everyone has the right to the highest attainable standard of physical and mental health. This includes access to all medical services, sanitation, adequate food, decent housing, healthy working conditions, and a clean environment. Access to health also involves four key elements, *viz.*, non-discrimination, physical accessibility, economic accessibility, and information accessibility. Health facilities and services should be accessible to everyone, especially the most vulnerable in society without discrimination on any prohibited ground. Beyond **A**ccess, we also need to speak about **A**vailability (**infrastructure** (e.g. hospitals, community health facilities, trained health care professionals), **goods** (e.g. drugs, equipment), and **services** (e.g. primary care, mental health) must be available in all geographical areas and to all communities; **A**ffordability;

[18] Christopher Mbazira, "The State of ESCR in Uganda Today: Reality or a Myth: Rights to Health, Education and Housing," in *Makerere Law Journal*, (2014): 184-193, at 188-189.

Acceptability and **D**ignity. Thus, Healthcare institutions and providers must respect dignity, provide culturally appropriate care, be responsive to needs based on gender, age, culture, language, and different ways of life and abilities, and they must respect medical ethics and protect confidentiality). Finally, there is the question of **Q**uality (All healthcare must be medically appropriate and of good quality, guided by quality standards and control mechanisms, and provided in a timely, safe, and patient-centered manner).[19]

Of particular concern in this discussion is the gendered character of the violations to the right to health, especially in relation to sexual and reproductive health and rights (SRHRs), an area in which CEHURD has done much work.[20] There is no doubt that women get a raw deal when it comes to the protection and enforcement of this right. Recent stories about Obstetric Violence – several mothers detained in a hospital for the failure to clear their debts,[21] and of another who died because she lacked UGX.50,000/= for an operation[22] - graphically reveal the gendered dimensions of not only "giving life", but of facing the consequences for new mothers of doing so: how can we stoop so low as to punish our mothers, sisters and daughters for performing the one function that is solely responsible for our existence on earth?

Why is healthcare a human right?

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19 See further ICESCR Committee General Comment No.14 on the Right to the Highest Attainable Standard of Health, Adopted on August 11, 2000, at: https://www.refworld.org/pdfid/4538838d0.pdf, and Joe Oloka-Onyango, "NGO Struggles for Economic, Social, and Cultural Rights in UTAKE: A Ugandan Perspective," in Makau Mutua (ed.), *Human Rights NGOs in East Africa: Political and Normative* Tensions, Philadelphia: University of Pennsylvania Press, 2009, at 93.

20 Beth Main Ahlberg & Asli Kulane, "Sexual and reproductive health and rights," in Sylvia Tamale (ed.), *African Sexualities: A Reader*, Cape Town/Dakar/Nairobi & Oxford: Pambazuka, 2011 at 313-339.

21 See Anthony Wesaka, "Monitor reader bails out four mothers detained by hospital," *Daily Monitor*, October 15, 2019 at 3.

22 Rosemary Nakaliri, "Abasawo bagaanye okumulongoosa lwa mitwalo 5 n'afiira mu kuzaala," *Bukedde*, October 15, 2019 at 7.

There are a number of reasons why healthcare and medical services (alongside other ESCRs) were initially ignored by lawyers and human rights activists. Historically, civil and political rights were prioritized because the rights to associate, to assemble and to speak were considered as more important rights for the elite and the ruling classes. On the other hand, ESCRs were of much lesser concern because the elite were either able to afford them, or they could use their privileged positions in the state or in the economy in order to access them. Needless to say, groups which have experienced a more marginal existence – women, young people, ethnic minorities and indigenous peoples among them – are in much greater need of the recognition of ESCRs.[23]

Human rights are inter-related, inter-connected and mutually-reinforcing.[24] Thus, while addressing one category of rights, we must always remember its links to the others. It doesn't matter if you have the right to vote if you are too hungry or too sick to get to the polling station. Freedom of Speech and Worship are important civil and political rights, but both of them have a clear linkage to the fundamental right to the highest attainable state of mental health. Being able to worship whom you want gives you peace of mind, and thus acts to secure you a better overall mental situation. In the same way, being muzzled from saying something, or conversely, being forced to say something you would rather not can obviously have a deleterious impact on the state of your mental health. Good health is intricately linked to respect for civil and political rights, such as freedom of expression, the right to associate, assemble and protest; freedom from torture, the rights to human dignity (*Ubuntu*), to a fair hearing and ultimately to life. Good health is also clearly determined by other basic ESCRs including access to safe drinking water and sanitation, nutritious

23 Oloka-Onyango, *op.cit.*, at 81-82.

24 This formulation goes back to the 1993 Vienna Declaration, which proclaimed that "All human rights are universal, indivisible and interdependent and interrelated."

food, adequate housing/shelter, education and safe working conditions.[25] The basic principle underlying recognition of the right to health is that no one should get sick and die simply because they are poor, or because they cannot access the health services they need.

Other very important rights are the right to equality of all individuals, coupled with the freedom from discrimination and the right to access information. As Ahlberg and Kulane point out, it is imperative to underscore the indivisibility of all categories of rights because it,

> *…recognises that individual women and men cannot, however, realize their sexual and reproductive health and rights without also realizing their broader human rights. The right to choose the number and spacing of their children cannot, for example, be realized unless they can also afford transport and user fees for services, such as family planning. Moreover, they must be free from poverty, and must have access to information and education and also be free from violence, whether from their partners (especially in the case of women) or from the state*.[26]

In short, without food, shelter or adequate health care you are not able to effectively exercise any of your so-called first generation rights. Not only is there a close connection between the different kinds of rights, but it is essential that if we are genuinely to consider ourselves persons concerned about human rights, we should strive to break down the barriers between them. It is ridiculous to imagine that you can be a whole human being if only one category of your rights is being satisfied.

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25 National Economic and Social Rights Initiative (NESRI), *What is the Human Right to Health and Health Care?* https://www.nesri.org/programs/what-is-the-human-right-to-health-and-health-care

26 Ahlberg & Kulande, *op.cit.*, at 313.

The human right to health guarantees a system of health protection for all. Everyone has the right to the healthcare they need, and to living conditions that enable us to be healthy. But in order to achieve this goal, the design of a healthcare system must also be guided by the following *procedural principles*, which apply to all human rights, viz., ***non-Discrimination***; ***Transparency***; ***Participation*** and ***Accountability***. At the end of the day the issue of accountability is the most important of all as it "… converts passive beneficiaries into claims holders, and identifies the state and other actors as duty bearers, who may be held to account for their policies, programmes and strategies to provide universal access to healthcare."[27] CEHURD's focus on litigation, social justice and empowerment is a critical factor in ensuring that greater accountability is realized in the arena of healthcare.

Assessing CEHURD's contribution through Litigation

Aside from Health Rights, CEHURD's three other areas of focus are Litigation, Social Justice and Empowerment. Litigation has been a particularly important strategy adopted by the organization and indeed, I believe that there is no other human rights group in the country which has so extensively deployed the tool. Hence, over the course of the ten years in which it has been in existence CEHURD has pursued a total of 35 strategic litigation cases covering a wide range of areas, summarized in Table 1 below:

TABLE 1

SUMMARY OF CEHURD's STRATEGIC LITIGATION CASES

CATEGORY	FOCUS	PENDING	COMPLETE
1. Ban on Sexuality Education	**RTI:** information accessibility	**1**	
2. Plant variety protection	**RTF: N/A**	**1**	
3. Mental health	**RTH:** non-	**6**	**4**

[27] John Mubangizi & Ben K. Twinomugisha, "The right to health care in the specific context of access to HIV/AIDS medicines: What can South Africa and Uganda learn from each other?" *African Human Rights Law Journal*, Vol.10, No.1 ((2010):105-134, at 128: http://www.ahrlj.up.ac.za/index.php/mubangizi-j-c-twinomugisha-b-k

	discrimination		
4. Access to free rabies vaccines	**RTH:** economic accessibility	**1**	
5. Theft of newborns	**RTH:**	**2**	
6. Access to information	**RTI:** information accessibility	**1**	**2**
7. Right to clean and healthy environment	**ENV:** General	**2**	
8. Quality of care	**RTH:** economic accessibility	**1**	
9. Termination of pregnancy	**RTH:** non-discrimination	**1**	
10. Availability of adequate health care services for autistic children	**RTH:** non-discrimination	**1**	
11. Disconnection of supply of electricity in public health facilities	**RTH:** physical accessibility	**2**	
12. SGBV and discriminatory penalties in sexual offenses	**RTH:** non-discrimination	**2**	
13. Access to medicines	**RTH:** non-discrimination	**1**	
14. Discrimination while accessing health care	**RTH:** non-discrimination	**1**	
15. Constitutionality of the Venereal Diseases Act	**RTH:** non-discrimination	**1**	
16. Professional conduct	**RTH:** non-discrimination		**1**
17. Detention of patient in a health facility	**RTH:** economic accessibility		**1**
18. Tobacco Control	**RTH:** information accessibility		**1**
19. Sexual offenses	**RTH:** General		**1**
20. Workers' rights	**RTW:** non-discrimination	**1**	
TOTALS		**25**	**10**

Key: ENV: right to a clean and healthy environment; RTF: right to food; RTH: right to health; RTI: right to information

A great deal can be said about this impressive record of litigation. First of all, it covers a wide range of issues extending from tobacco control to access to information to care services for autistic children. Secondly, not all the cases are on constitutional matters, which although important are rather esoteric. A good number of the cases are on issues of accessibility, non-discrimination and healthcare infrastructure which are basic questions that not only affect large numbers but also the most vulnerable individuals in society. Lastly, the highest number of cases (6) has been on mental health, representing a major achievement in an area that has long been neglected. Indeed, in a landmark decision brought by CEHURD, the Constitutional Court declared as derogatory and unconstitutional several provisions of the Penal Code and the Trial on Indictments Act which not only discriminated against persons with mental health ailments, but also used derogatory language and outmoded methods of intervention in order to treat them.[28] The court even went further to order appropriate reformulations of the provisions in question.

Needless to say, the data also reveals several problems with the use of litigation as a strategy of empowerment or social justice. First of all, only 28% of the cases filed have reached final resolution. Moreover, that resolution is not always satisfactory or in favour of CEHURD. Some of the decisions are mixed. This fact points to two broad issues, the first with the use of litigation as a mechanism for achieving respect for rights, and the second with the institution within which that mechanism is deployed, i.e. the courts of law. Litigation is tedious, drawn-out, time-consuming and (depending on the issue) expensive. Moreover, some of the benefits of taking a matter to court may not be immediately obvious. There is also no guarantee of success which means that there is a need to be especially careful and tactical in pursuing litigation as a strategy.

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[28] *CEHURD & Iga Daniel v. Attorney General*, [Constitutional Petition No.64 of 2011].

A close reading of some of the cases filed by CEHURD reveals that sometimes the strategy employed was the wrong one, or they suffered from significant procedural mistakes in the preparation and packaging of the case and even over the basic questions of the forum in which it should be filed. Some of the pleadings and the tactics used have also come up for criticism by the Bench.[29] These are the expected mistakes of a ten-year old, and betray the fact that acting like an adult is more difficult than actually being one.

Of course, the courts themselves are sometimes part of the problem. Many of them are still very conservative and have not yet come round to the belief that healthcare is indeed a justiciable human right. Others among them are so deferential to the Executive and fear to pass judgment on these issues out of an inordinate (but confused) respect for the doctrine of Separation of Powers.[30] While our courts are becoming more familiar with the Structural Interdict as a useful mechanism in compelling Executive compliance with directions and orders from the judiciary – as in the *Amama Mbabazi* and *James Muhindo* cases[31]—one senses a lingering reluctance to use it, a hesitation clearly demonstrated in the recent maternal case re-hearing by the Constitutional Court where the learned justices queried whether such a remedy was of any utility given the poor response of the Executive to the orders.[32] It is also clear that our courts sometimes issue judgments in complete ignorance of the law. In the recently-decided case that CEHURD brought dealing with the provision

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29 See judgment in the case of *CEHURD & Ors v. Nakaseke District Local Administration*, Civil Suit No.111 of 2012.

30 See, for example *The Institute of Public Policy Research (IPPR) (Uganda) v. The Attorney General*, (Miscellaneous Application No.592 of 2014, arising from Miscellaneous Cause No.174 of 2014).

31 See *Amama Mbabazi v. Y. K. Museveni* (Presidential Election Petition No.1 of 2016) on electoral law amendments, and *Muhindo James & ors. v. The Attorney General* (ordering government to formulate eviction guidelines and report back to the court within seven months thereof).

32 See Anthony Wekesa & Juliet Kigongo, "Maternal deaths case: Lawyers give submission," *Daily Monitor*, October 1, 2019 at 4.

of anti-rabies vaccines, the learned judge in the case invoked the "Political Question Doctrine" citing as authority the Constitutional Court decision which had been overturned by the Supreme Court over a year prior![33]

Does this mean that CEHURD should abandon litigation as its main strategy? I don't think so, but it certainly means that CEHURD needs to devote much more energy going forward to both refining and improving its litigation strategy, on the one hand, and also engaging with the Judiciary, on the other. Furthermore, the use of courts needs to be linked to broader social struggles in terms of addressing political and economic issues. This also means that CEHURD should explore other options such as cross-sectional mobilization, advocacy and direct action in more detail. Not all of CEHURD's eggs should be put in the litigation basket.

Beyond the substantive issues which have been taken up in litigation, it is also necessary to examine the different duty-bearers against whom CEHURD has petitioned. These are summarized in the following table:

TABLE 2

CEHURD RESPONDENTS

RESPONDENT	NUMBER OF CASES
Attorney General	17
Local governments	8
Government hospitals	5
Statutory bodies	4
Medical personnel	4
Private hospitals	4
Private organizations	3
Individuals	2
Church hospitals	2
Doctor's rights	1

Source: CEHURD data, October 2019

[33] See *CEHURD & 3 Ors. v. Wakiso District Local Government*, Civil Suit No.170 of 2015, at 19-20.

The data in the table above reveals a good deal of interesting information. The Attorney-General, as representative of the central government, is respondent in the largest number of cases (17). Local governments are next on the list (8), followed by government hospitals (5), while statutory bodies, medical personnel and private hospitals each have four (4). Private organizations, Church hospitals and individuals come next (3). In one instance (on tobacco control) CEHURD and the Attorney General joined hands to petition against the lead tobacco manufacturer in the country, while in another CEHURD supported the Uganda Medical Association (UMA) in pursuing improved conditions of work. These last two cases demonstrate that CEHURD has found common ground with government on a particular issue and also that medical personnel (doctors and nurses) are not always on the receiving end of their litigation. I will return to this point after making some reflections on the broader conceptual issues implicated by the litigation work in which CEHURD has been involved. I link them to the implications of addressing human rights deficits as an instrument in the struggle for Social Justice – the second element of CEHURD's mission.

III. HUMAN RIGHTS AS A MECHANISM OF SOCIAL JUSTICE

There are several broader conceptual issues of human rights concern which are implicated in the work done by CEHURD but for the current purposes I will only consider two, *viz.*, the focus on the state as the primary actor in the violation, realization and enforcement of the right to health, and secondly, the need to understand the realization of human rights as a product of struggle, political, economic and social. Linked to this latter point is the question of whether "human rights" is the most appropriate tool to deploy within a context of governmental dismissal of human rights criticism; the very poor levels of enforcement of court orders and the lingering problem of the failure to fully implement laws and policies on health services.

Regarding the issue of the State, it is quite clear that private actors have gained a significant position in the health sector, whether alone or more frequently in

partnership with government. The critical question then is the extent to which appropriate mechanisms are in place in order to ensure that such private actors do not undermine the realization of the right to health. Already issues of concern relating to public-private-partnerships (PPPs) have emerged in the arena of education[34] and infrastructure which are also manifesting in the health sector.[35] The recent debacles over private pharmacies in government hospitals[36] and the concerns expressed about the unhealthy recourse to caesarean-(C)-section births in private hospitals is just the tip of the ice-berg.[37] Indeed, the reaction of the government is to focus on the symptoms and not the causes of a much larger problem.[38] PPPs need much more critical scrutiny, especially because one "P" is conspicuously missing from this formula, i.e. the People, especially those who are in the lower income strata of society.[39] As Philip Alston points out with respect to the manner in which poor people are treated by officialdom:

> *Low-income people are often sidelined, blamed and objectified, even by those who are ostensibly their advocates and well-intentioned policymakers. This is on top of the endeavours of many politicians to shamelessly scapegoat those facing hardship, and especially those who have been historically marginalised. Too often, officials and policymakers are happy to remain ignorant of the immense*

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34 ISER, *A Threat or Opportunity: Public-Private Partnership in Education in Uganda*, August 2016.

35 ISER, *Achieving Equity in Health: Are Public-Private Partnerships the Solution?* August 2019.

36 Brian Arinitwe, "About the directive to close privately owned pharmacies in govt hospitals," *New Vision*, October 11, 2019 at 16.

37 See Lilian Namagembe, "C-section births: Govt accuses hospitals of greed," *Daily Monitor*, October 14, 2019 at 5, and Carol Natukunda, "Fear, money fuelling C-sections," *New Vision*, October 20, 2019 at 6.

38 For the debate on the issue of pharmacies, see, *inter alia*, Cecilia Okoth, "President's directive on pharmacies to hurt patients, stakeholders say," *New Vision*, October 11, 2019 at 9

39 Uganda Consortium on Corporate Accountability, *Business and Human Rights in Uganda: A Resource Handbook on the Policy and Legal Framework on Business and Human Rights in Uganda*, September 218 at 60.

> *challenges that families and individuals face, of the harms and indignities that accompany unemployment and low pay, and of the actual wishes of poor people for pragmatic, systemic change.* [40]

The above quotation points to a critical problem. Although the "Public" in the PPP formula ostensibly represents the interest of the People, it is quite clear that this is not necessarily always the case. Civil society and popular movements have been largely excluded from the discussions and agreements which have resulted from this new mode of doing business, and the dangers involved are self-evident. Given the conflicting interests between "public" healthcare provision and the profit-oriented private enterprises, the resultant PPP synergy cannot possibly be healthy!

In a bid to become more engaged with the developments in PPP in the health sector, CEHURD could borrow from the Brazilian model of the *conselhos de saúde* (health councils) which operate at the municipal, state (district) and national level.[41] These councils include civil society actors, health workers, local government representatives and health bureaucrats who come together on a regular basis to approve health plans and to audit health spending. They propose initiatives that can be adopted and also offer constructive criticism about the sector.[42] In this respect they have evolved a kind of *co*-governance which mandates popular participation in the management of health services,

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40 Philip Alston, "Much Ado About Poverty: The Role of a UN Special Rapporteur," *Journal of Poverty and Social Justice*, Vol.27, No.3, (2019): 1–7, at 2, at: http://docserver.ingentaconnect.com/deliver/fasttrack/tpp/17598273/jpsj-d-19-00041_uploaded_17092019_1568707425523.pdf?expires=1570894336&id=guest&checksum=9EC7C77C1055CA46CCD8C5BD96B3FA96.

41 Andrea Cornwall, Silvia Cordeiro and Nelson Giordano Delgado, "Rights to health and struggles for accountability in a Brazilian municipal health council," in Peter Newell & Joanna Wheeler (eds.), *Rights, Resources and the Politics of Accountability*, London/New York: Zed Books, 2006, at 144-162.

42 *Ibid.*, at 155.

rather than leaving it exclusively to the bureaucrats and the privateers.[43] CEHURD can build on its initiatives in the Tobacco control case in order to reach out to state functionaries to push for the creation of an alliance of different forces pushing for a common beneficial goal of improved attention to the right to health and also move control over the sector out of elite capture. These measures will greatly bolster CEHURD's efforts in the arena of social justice.

But more importantly, as CEHURD pushes into its next decade, it needs to build stronger alliances with other civil society groups working on human rights and social justice issues across the board. CEHURD cannot afford to remain focused on only its traditional work – and by implication the work of similarly-situated organizations. If they do, there will be little impact on wider society and the realization of the goals of social justice. CEHURD needs to critically examine the way in which it relates to other actors across the board, and to revisit the issue of solidarity within civil society vs. the compartmentalization of social, economic and political struggles. Ultimately, forging such linkages will bolster the achievement of CEHURD's last mission goal, that of development.

IV. DEVELOPMENT AS AN INSTRUMENT OF EMPOWERMENT

Although the last moniker in CEHURD's title is "development" it is the least developed of the four mission-goals of the organization. I would like to suggest that given all the developments which have taken place in the economy, the key question that should be asked is the extent to which economic developments in society at large are improving the livelihoods of the poor and the marginalized. In this respect we need to get beyond and challenge the hegemony of Neoliberalism which has afflicted Ugandan society for the last several

[43] *Ibid.*, at 145-147.

decades.[44] The unchallenged notion that the private sector is superior to the public sector needs to be seriously questioned, as does the idea that the government should take a backseat in the regulation of services such as health, education and water.

In my humble view, the key question in the quest for development is not riches or resources (GDP) alone, but how those riches are utilized and distributed. And there is no doubt that the manner in which we have distributed our riches so far leaves a great deal to be desired. How can you decide to spend over half a billion dollars on a single hospital project such as the one at Lubowa when the same amount of money can create and equip numerous health centres around the country? The question of prioritization aside, the lack of transparency around the project—graphically demonstrated by the barring of the line minister, her permanent secretary and members of Parliament from the construction site – points to a serious problem.[45]

The issue of development is fundamentally an issue of both accountability and of empowerment.[46] Seen from this perspective, involvement in the politics and economics surrounding development interventions is inevitable. Although couched in technocratic terms, the issue of development is essentially a political one. In this respect, development needs to be critically unpacked and considered as an instrument of empowerment.

How, therefore, do we unpack development? I would like to suggest that the first point of intervention needs to be the fiscal or budgetary arrangements

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44 Nicholas F. Stump, "Critical Explorations of Human Rights: Recent and Selected Works," *Legal Reference Services Quarterly*, (2019), DOI: 10.1080/0270319X.2019.1656458.

45 Cissy Kagaba, "Exercise transparency in Lubowa hospital dealings," *The Observer*, August 14-20, 2019 at 26.

46 Sam Hickey, "Beyond the Poverty Agenda? Insights from the New Politics of Development in Uganda," *World Development*, Vol.43, March 2013, Pages 194-206, at: https://www.sciencedirect.com/science/article/pii/S0305750X12002215.

around which different governmental activities are organized. I believe we need to start with the budget, the basic contours of which are summarized in the table below:

TABLE 3

COMPARATIVE BUDGET OVERVIEW, 2020/2021

SECTOR	2019/2020				2020/2021		
	UGX	%TAGE	RANK	UGX	%TAGE	RANK	%CHANGE
1. Agriculture	1.05 trillion	4.62	7	950 billion	5.21	7	+0.59
2. Energy	3.00 trillion	13.21	4	2.46 trillion	13.50	3	+0.29
3. Security	3.62 trillion	15.94	2	2.06 trillion	11.31	4	-4.63
4. Works & Transport	6.40 trillion	29.19	1	5.05 trillion	27.73	1	-0.46
5. Health	2.58 trillion	11.36	5	1.55 trillion	8.51	5	-2.85
6. Education	3.39 trillion	14.93	3	3.28 trillion	18.01	2	+3.08
7. Water & Environment	1.09 trillion	4.80	6	1.30 trillion	7.13	6	+2.33
8. Public Administration	970 billion	4.27	8	956 billion	5.25	8	+0.98
9. Electoral Commission	229 billion	1.00	9	229 billion	1.25	9	+0.25
10. Tourism	193 billion	0.85	10	193 billion	1.05	10	+0.20
11. Judiciary	181 billion	0.79	11	181 billion	0.99	11	+0.20
	22.703 trillion	**100.00**		**18.209 trillion**	**100.00**		

Source: Moses Kyeyune, "Govt names top targets for 2020/2021 budget funding," *Daily Monitor*, October 15, 2019 at 6.

A great deal can be said about the figures above, but let us only focus on those which relate to the Health sector. Although the general budget for 2020/2021 is less than the 2019/2020 projection by nearly UGX4.5 trillion, on the face of it, things don't look too bad for the Health Sector. First of all, Health retains its rank at 5th out of the eleven sectors. While it should ideally be in the top-three, one would not be inclined to quibble too much over its present ranking.

However, the positioning of Health conceals more insidious developments which may not be immediately obvious at first glance of the data. In the first instance Health is only one of three sectors (the others being Security and Works and Transport) which will witness a reduction in its budgetary percentage. This represents a drop of 2.85 percentage points on the 2019/2020 outlay. All the other eight sectors will get a boost in their funding, ranging from 0.20% on the lower end for Tourism and the Judiciary, to Education at the top that will see its budget rise by 3.08%. Hence, the allocation to Health will drop from 11.36% in the 2019/2020 budget to 8.51% in 2020/2021, a proportion comparable to the 2014/2015 situation.[47] Secondly, this reduction is a further step away from the 15% commitment reflected in the Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases.[48] Thirdly, with the numerous problems facing the sector such as the funding of essential drugs, poor health facilities and underpaid medical personnel, the projected budgeting reflects a veritable slap in the face to the poor of the country.[49] At the end of the day, any reduction to the general budget of the health sector will have individual (life-altering) implications for the ordinary Ugandan as the *per capita* allocation will likewise be reduced.

However, the most problematic aspect of the proposed budget is one of conceptualization. One of the basic principles underlying the protection of ESCRs under International Law is that states should endeavour to *progressively realize* the rights they have committed to observe in the International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 8A of the 1995 Constitution stipulates that the NODPSP – including the right to health – are mandatory. Whichever way the proposed reduction is packaged, it represents a regression from these commitments. In sum, the proposals graphically underscore the point made by the Centre for Economic

47 Ssali, *op.cit.*, Figure 9.2, at 185.

48 https://www.eldis.org/document/A19768.

49 See Mbazira, *op.cit.*, at 189-191.

and Social Rights, "… we don't live in a world of scarcity, but one where resources are distributed in a grotesquely unfair way, failing to reach those who need them the most."[50] The implications for the proposed budgeting on the Health sector are thus fairly clear, and should be taken up by CEHURD with vigour. And there are two dimensions to this struggle; the first to ensure that the percentage allocation given to the Health sector either remains the same or is increased, and secondly, to review the allocations within the sector in order to ensure that the interests of the most marginalized members of society are fully catered for. We need to avoid the further *Lubowarization* of the sector, i.e. a situation in which the resources of the sector are skewed mainly to benefit the affluent (or state-connected) minority.

V. ONWARDS TO THE NEXT TEN

Given the tribulations involved in ensuring the implementation of the right to health in such a challenging socioeconomic environment what should CEHURD be doing in the next ten years of its life – the time when it will assume full and genuine adulthood? As should have been made clear from the preceding analysis, CEHURD needs not only to think outside the box in which it has been operating, the box itself needs to be re-thought through an approach which is multifaceted.

In the first instance, CEHURD needs to become much more critically engaged with the policy debate over right to health issues.[51] Among them are improved health and rights literacy, the former for the public at large,[52] and the latter for

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50 CESR, *The SDGs and Gender Equality: Empty Promises or Beacon of Hope?*, at: http://www.cesr.org/sdgs-and-gender-equality-empty-promises-or-beacon-hope.

51 A leaf with respect to policy engagement that CEHURD could borrow can be taken from the example of ISER, *Shortchanging social and economic rights: Why Parliament should not pass the Public Finance Bill, 2012 in its current form*, at: https://www.iser-uganda.org/images/downloads/ISER_Policy_Advocacy_Note_on_Public_Finance_Bill_2012.pdf.

52 Nata Menabde, "Health Literacy and the SDGs," in United Nations Association—UK (UNA-UK), *Sustainable Development Goals: From Promise to Practice*, London, 2017, at 30-31.

the members of the health profession.[53] Ultimately, there is also a need to consider more activist interventions. It needs to also turn attention to the issue of drug supply, drug use, and drug distribution – symptomatic of the over-prescription and medicalisation of health treatments – and all its varied dimensions and implications for the full realization of the right to health. CEHURD needs to reinvigorate the debate about issues of enforcement, and to design new strategies in order to get the Executive to respond to legitimate court orders, for example by resorting to the mechanism of private prosecutions of state officials when faced with recalcitrance or impunity. I also note that CEHURD has not demonstrated much interest in the alternative domestic avenues through which the RTH can be pursued such as the Equal Opportunities and Human Rights commissions, nor the regional bodies such as the East African Court of Justice and the African Commission on Human and Peoples' Rights, let alone the very many international mechanisms that are available.

Although Uganda has not yet adopted the optional protocols to the ICESCR or CEDAW which would permit individual petitions, it has done so on the Convention on the Rights of Persons with Disabilities (CRPD), and on the Children's Rights Convention (CRC).[54] CEHURD should join in solidarity with the campaigns on ratification being pursued by other human rights organizations, and also explore using some of the international mechanisms which can address some of the bottlenecks they have faced in the realization of the right to health domestically. I also notice that CEHURD has been conspicuously silent on the issue of the rights of sexual minorities. Sex workers, men-who-have-sex-with-men, lesbians, and transgender persons need

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53 Moses Baguma, The Law as an answer to health-related conundrums," *Makerere Law* Journal, (2015): 1-6, at 4.

54 United Nations Human Rights Office of the High Commissioner, *UN Treaty Body Database*, https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx?CountryID=182&Lang=EN.

special attention from a right-to-health perspective as do prisoners and refugees, especially with respect to addressing the varied impacts of HIV/AIDS.[55] CEHURD thus needs to be more sensitive to vulnerabilities within the vulnerabilities. It has done well with respect to gender and class. But how about age, sexual orientation, disability and ethnic minority status?

CEHURD will also need to improve its engagement with the policy-making processes in the sector in order to ensure that the appropriate right-to-health considerations are taken into account. Human Rights Audits (HRAs) or Human Rights Impact Assessments (HRIAs) should be designed in order to provide a sieve for all future policy and legislative interventions which may be designed. For example, CEHURD's voice would have been critical in the ongoing debate about the National Health Insurance Bill.[56] As the premier organization which provides a perspective that marries Law and Public Health, going forward CEHURD should position itself as the most important civil society actor/think tank to provide a critical input into all these areas which are of crucial relevance to the realization of the right to health in Uganda.

Finally, CEHURD also needs to give some consideration to its professional and employment profile, summarized in the tables below:

TABLE 4

GENDER AND PROFESSIONAL PROFILE OF CEHURD BOARD

POSITION	GENDER	PROFESSION
CHAIR	Male	Lawyer
VICE-CHAIR	Male	Psychiatrist
TREASURER	Male	Health Economist
DIRECTOR No.1	Female	Public Health specialist

55 Global Commission on HIV and the Law, *Risks, Rights and Health*, New York, UNDP (July 2012), at 26-61.

56 See Jordan Tumwesigye, "A Review of the National Health Insurance Bill and its potential impact on the access to health services," *Makerere Law Journal*, (2018): 107-120, and Moses Walubiri, "Legislators start scrutinizing 2019 Health Insurance Bill," *New Vision*, October 2, 2019 at 7.

DIRECTOR No.2	Female	Trade/fiscal specialist

Source: CEHURD data, October 2019

Although the Board is fairly representative of the interests which are involved in healthcare in the country, consideration should be given to including a mainstream medical doctor both on the Board and among its staff, given that the interests of the mental health community are well represented and even well reflected in the litigation caseload CEHURD has taken up. It would also be useful to recruit a public policy specialist given that this kind of engagement will be critical going forward.

On its part, the makeup of CEHURD's staffing is summarized in the table below:

TABLE 5

SUMMARY OF CEHURD EMPLOYEE PROFILE

PROFESSION	**NUMBER**		
	FEMALE	**MALE**	**TOTAL**
Lawyer	9	5	14
Social Worker	3	1	4
Business Administrator	3	1	4
Journalist	1	1	2
Public Health Specialist	0	2	2
Accountant	1	1	2
Trained Medical Nurse	0	1	1
Trained Teacher	1	0	1
Information Technology Specialist	0	1	1
Computer Engineer	0	1	1
Professional Driver	0	1	1
Economist	1	0	1
Communication Expert	0	1	1
Security Officer	0	1	1
Office Cleaner	0	1	1

Teacher	0	1	1
Graphics Designer	1	0	1
TOTAL	**20**	**19**	**39**

Source: CEHURD data, October 2019

CEHRUD scores well on the plane of gender parity, however, some reform needs to be carried out with respect to the professional cadres that are in control of the organization. Hence, out of 39 members of Staff, the preponderance (35%) is made up of lawyers. In contrast, only 8% can be described as Health-related professionals. As is the case with the Board, there is no public policy individual on the Staff. Going forward, there is a need to reduce the preponderance of lawyers and expand the pool of personnel who have qualifications in the Health sector.

VI. CONCLUSION

I hate to use clichés, but sometimes they are the most useful tool to explain a particular situation. Since we are talking about Health, the most appropriate cliché in this instance is: *Prevention is MUCH better than cure*. I don't know how many people in this audience have ever suffered from cholera, dysentery or typhoid, but we all know that it is much better never to have been a victim of these diseases than to look forward to being cured of them. Hence it is quite clear that more effort should be placed on methods of preventing violations of the right to health as opposed to looking for cures to them. Unfortunately, the law and the legal mechanisms we have highlighted such as litigation and which CEHURD has concentrated on are only part of the cure. Moreover, they are a blunt cure. Sometimes they work. However, many times they may lead to more frustration, more delay and less satisfactory results especially if the court action is not followed by concerted government intervention. As CEHURD moves into the next decade of its existence it needs to supplement its heavy focus on legal remedies with a multi-pronged approach to addressing the multiple complexities that characterize this area of human livelihood and rights-protection.