

FRAMEWORK CONVENTION ON GLOBAL HEALTH

How a binding international treaty may promote equity and enhance the realization of the right to health in Uganda



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social justice in health



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LIST OF ACRONYMS

ACHPR	African Charter on Human and Peoples Rights
ACRWC	African Charter on the Rights and Welfare of the Child
AIDs	Acquired Immune Deficiency Syndrome
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CMWF	Convention on Migrant Workers and Members of Their Families
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
ESCRs	Economic, social and cultural rights
FCGH	Framework Convention on Global Health
HIV	-Human Immune Virus
HSSP III	-Health Sector Strategic Plan III
ICESCR	International Covenant on Economic, Social and Cultural Rights
MDGs	Millennium Development Goals
NHP II	National Health Policy II
NODPSP	National Objectives and Directive Principles of State Policy
OHCHR	Office of the High Commissioner for Human Rights
PWDs	Persons with Disabilities
SDGs	Sustainable Development Goals
TB	Tuberculosis
UCG	Uganda Clinical Guidelines
UDHR	Universal Declaration of Human Rights
UNCESCR	United Nations Committee on Economic, Social and Cultural Rights
UPR	Universal Periodic Review
WHO	World Health Organisation

EXECUTIVE SUMMARY

International human rights treaties and instruments guarantee and protect the right to the highest attainable standard of physical and mental health (right to health). At the national level, the right to health is not expressly protected in the country's Constitution but it is somehow recognized in the Constitution's Preamble (National Objectives and Directive Principles of State Policy, NODPSP); and in provisions recognizing related rights in the Constitution and other national laws.

Besides the legal impediment, there are a number of challenges to the realization of the right to health in Uganda and other countries in the Global South, exacerbating health inequality within and between these countries and countries in the Global North.

The international human rights framework has not been effective in closing inequalities and expanding the realization of the right to health. It has for instance, been pointed out that the right to health as crafted in the current international human rights regime is inadequate in "addressing extremely poor health" and "detrimental reliance on gradual steps of 'progressive realization' and inadequate mechanisms for implementation and enforcement" (Gable and Meier (2013).

The existing regime has been found not to address issues of global health governance and the responsibilities of states toward global health, while accountability and enforcement of compliance has not been sufficient.

It is on the basis of the above that a Framework Convention on Global Health (FCGH) is being proposed as a legally binding global health treaty tailored to addressing health disparities, setting a global health governance system, and defining clear responsibilities in global health.

The FCGH is being conceived to go beyond the existing human rights framework and its weaknesses. So far, three approaches have been suggested in the FCGH Platform:

- 1) Community participation in treaty monitoring;
- 2) Inclusive platforms that engage governments and other stakeholders to remedy non-compliance; and
- 3) Effective incentives and sanctions.

In the case of Uganda, it is believed that although the Convention may do little to overcome the challenges associated with domestication and implementation of the international obligations Uganda has committed to, the Convention along with the advocacy around it, will be vital in contributing to the right to health in Uganda.

The way the Convention is crafted and advocacy can help with implementation; our challenge is to craft it in a way that does. This is in the sense that it would help Uganda CSOs feed into the global movement and advocacy towards the FCGH. Also vital is the assumption of global responsibilities, which in the context of extra-territorial responsibilities would help Uganda's health sector benefit from the resources and expertise at the disposal of other countries.

The proposed FCGH is an opportunity but also a challenge. The opportunity is to establish an effective framework to address health disparities, strengthen global health governance and hasten the realization of the right to health for populations. On the other hand, the challenge is how to put in place such a framework and build in mechanisms to facilitate implementation and compliance. The Uganda civil society should join the global FCGH advocacy movement the resulting framework addresses the country's needs and priorities.

1. BACKGROUND

SUMMARY

A Framework Convention on Global Health (FCGH) is proposed as part of supranational regulations based on a new international consensus concerning the key challenges to global health and informed by weaknesses in the current systems of global governance

FCGH PLATFORM

1.1 Introduction

The international community has deployed various approaches to protect and promote socio-economic well-being, including ensuring physical and psychological well-being. This has included the adoption of international standards that define different aspects of economic and social welfare that states are obliged to follow. Some of these standards have been crafted with guidance from human rights norms, which have defined such rights as the economic, social and cultural rights (ESCRs).

The international standards related to ensuring that people are healthy and have access to goods and services necessary for good health are among others contained in the international human rights instruments which have been adopted at both the United Nations (global) level and at the regional (continent) levels. These instruments, which are in the form of treaties, have defined human rights norms, including the right to the highest attainable standard of mental and physical health. This is in addition to establishing an elaborate institutional framework for the implementation of the treaties.

Unfortunately, as is illustrated below, effective use of the international human rights framework has been hampered by a number of challenges. This has among others arisen from weaknesses in the mechanisms created by the treaties and the reluctance, and in some cases inability, of most states to effectively implement the standards proclaimed by the framework.

The treaties and their implementation mechanisms have also not been able to adequately address issues of equity in access to health goods and services between and among countries, or to build international structures which would ensure such equity. Questions have arisen regarding the extent to which the human rights framework is holding states accountable as far as health issues are concerned and the extent to which, globally, people are taking part in health related decisions which affect them.

In the case of Uganda, the country has not fully domesticated the human rights norms contained in the international treaties. The right to the highest attainable standard of physical and mental health is for instance not expressly protected as part of the rights guaranteed by the country's Bill of Rights in its 1995 Constitution. The country has also not fully discharged its treaty obligations by for instance effectively submitting reports on the implementation of the rights contained in the treaties it has ratified. Uganda is also currently challenged to fully implement the recommendations which have emerged from the international and regional treaty monitoring bodies.

In addition to ratifying the international and regional treaties, Uganda is one of the countries which in the year 2000 committed to the Millennium Development Goals (MDGs), which are targets defined to be achieved by subscribing countries by the year 2015 and endorsed by 191 heads of state and government in September 2000.

The MDGs have 3 goals that are directly relevant to health. The first goal, contained in MDG 4, is reducing under-five child mortality by two thirds by 2015; the second, in MDG 5, is improving maternal health through reduction by three quarters of the maternal mortality ratio and ensuring access to universal reproductive health by 2015; and the third, in MDG 6, is halting and start to reverse the spread of HIV/AIDS by 2015, achieve by 2010 universal access to treatment for HIV/AIDS for all in need of the same, and have halted and begin to reverse the incident of malaria and other major diseases by 2015.

The extent to which these targets have been achieved globally is mixed and straddles between successes, stagnation and slowness, and in some cases worrying reversal. These targets are important to the extent that the failure to meet some of them in Uganda is an indicator of the challenges which Uganda is facing as a country in realising the right to health. The factors which have hindered the realisation of the goals could be used to highlight some of the issues which the proposed Framework Convention on Global Health (FCGH) could address from a Ugandan perspective.

According to the 2013 Millennium Development Goals Report for Uganda (Ministry of Finance, 2013), the country is on track as far as under-five child mortality is concerned, having reduced the same from 156 in 1995 to 90 in 2011 and is targeted at 50 in 2015. In contrast, achievement of the maternal related indicators has been slow; maternal mortality per 1000 live births has reduced only from 506 in 1995 to 438 in 2011 and the country is unlikely to achieve the target of 131 by 2015. Universal access to reproductive health is also progressing at a slow pace; for instance, access to contraceptives has only moved from 14.8% in 1995 to 30% in 2011.

As far as the HIV prevalence is concerned, there has been a worrying reversal. For instance, the prevalence rate for the female category of 15 – 19 years has moved from 2.9% in 2004/05 to 3.7% in 2011. Similarly, in the female category of 20 – 24 years, it has moved from 6.3% to 7.1% during the same period. According to the 2011 Uganda Demographic and Health Survey (UBOS 2012), only about half of children in Uganda are fully immunised (UBOS 2012); yet, although HIV testing has increased, only 38% of women and 43% of men have comprehensive knowledge of HIV/AIDS prevention and transmission (UBOS 2012).

It is because of some of the above challenges in the health sector globally and within countries that suggestions have been made for the adoption of the FCGH. The FCGH is proposed as part of supranational regulations based on a new international consensus concerning the key challenges to global health and informed by weaknesses in the current systems of global governance (UBOS 2012). The FCGH is proposed to be a comprehensive strategy to reduce health inequalities and address the massive inequalities in the health sector faced by millions of people all over the world.

According to Gostin (2012), the inequitable distribution of disease and early death between the rich and the poor is the most enduring global health challenge. It is argued that life expectancy is 26 years shorter in sub-Saharan Africa than in most of Europe and America. For instance, in 2012, life expectancy for the United Kingdom stood at 81 and was 59 in Uganda.¹

Thus, the aim of the FCGH is among others to ensure that there is increased life expectancy and that health issues are dealt with from a human rights perspective and other good governance values such as accountability and equal participation for all. Hence, the FCGH is meant to be a legally binding global health treaty grounded in the right to health and aimed at improving the health status of all globally, with an emphasis on reducing health inequities.

¹ World Bank Data, Life expectancy at birth, available at <<http://data.worldbank.org/indicator/SP.DYN.LE00.IN>> (accessed on 14th August 2014).

1.2 Purpose of paper

This paper was conceived as an issues paper to help highlight some of the discussions at the global level around the FCGH and how these could inform similar discussions at the Ugandan level. The paper is also intended to highlight some of the health issues in Uganda and make suggestions on how best the Convention could contribute to addressing these. Part I puts the paper in context by elaborating the concept of framework conventions in international law, relating this to proposals for the FCGH.

The nature of the discussions going on in terms of relevance and merits and demerits of the FCGH are profiled. Part II discusses the challenges which Uganda is facing in giving the right to health domestic legal effect and discharging the international obligations related to this right. This is in addition to some of the challenges which Uganda's health sector is facing.

Part III discusses the relevance to Uganda of the FCGH and the extent to which it could be used to address some the health related challenges which Uganda is facing.

2. ADVOCACY TOWARDS THE FCGH

SUMMARY

Framework conventions provide broad requirements to the subscribing parties (states), leaving room and flexibility to fulfill the agreed requirements through more detailed, subsequent agreements or national legislation

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The concept of framework conventions is a relatively new approach in international law making. What differentiates framework treaties from other treaties is the fact that framework conventions establish broader commitments for the parties and leave the setting of specific targets either to subsequent more detailed agreements or to national legislation.² Conceptually, the advantages of this form of convention have been indicated thus:

Framework conventions elevate the political will for action and leave room for consensus on the details of the action itself for a later stage. They are effective in creating a coherent treaty regime based on a general overarching agreement. Thus, their advantage is that a consensus can be more easily achieved by the parties, as first they agree on general and basic principles which could guide, if the parties wish so, the possible further negotiation of detailed and targeted protocols to the treaty. As the issues in question are usually addressed through the development of national policies and strategies, framework conventions are inherently flexible; allowing governments the discretion of how to achieve the agreed objectives based on their countries' capabilities.³

2 See Economic Commission for Europe, Committee on Housing and Land Management Framework Convention Concept, Note from the Secretariat, available at <http://www.unece.org/fileadmin/DAM/hlm/sessions/docs2011/informal.notice.5.pdf> (accessed on 15th August 2014)

3 As above.

Although many treaties within the conventional treaty system addressing a number of issues, the effectiveness of these treaties has in some cases been called into question. In the case of human rights, as is demonstrated later, these treaties have not been able to establish a comprehensive framework within which the rights are realised and responsibilities shared. As far as the right to health is concerned for instance, the treaties have defined standards which many states, including Uganda, may not be in position to discharge without shared global responsibilities. It is failings of this nature that the concept of framework conventions is gaining ground. This is mainly because these conventions take into account countries capabilities and create shared global responsibilities.

Examples of framework conventions which have been adopted include the United Nations Framework Convention on Climate Change, 1992; the European Framework Convention on the Protection of National Minorities, 1995; and the World Health Framework Convention on Tobacco Control, 2005.

It is against the above backdrop that advocacy for a framework convention on health has emerged. Among the groups pushing for this has been the Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI). JALI has since been subsumed in a broader FCGH Platform, which will engage stakeholders on and advocate for the FCGH.

On its website, JALI, and now the FCGH Platform, effort emerged as a response to the vast and unconscionable inequalities in health that disfigure our world. Inherent to this FCGH effort is the need to deepen the recognition among people and governments in all regions of the world, in the Global South and Global North, of the mutual responsibilities for improving the health of the world's population, especially the poorest and most disadvantaged people, and to clarify these responsibilities.

In the FCGH discourse so far, some have raised the question of whether this cannot be addressed within the current United Nations and regional human rights treaty frameworks. Some of the voices opposed to the FCGH idea have expressed fear that the convention would simply be creating another treaty and adding to the already weak international law.

Oona A. Hathaway (2002), for instance, has wondered whether human rights treaties are really complied with, and if at all they have an effect on state behavior.

Writing specifically about the FCGH proposal, Hoffman and Røttingen (2013) have alluded to some of the possible shortcomings of the proposal for the FCGH. Their concerns are based on three fears: duplicating effect; possible lack of feasibility; and questionable impact. However, the authors indicate that their objective is to set out concerns that need to be addressed, which in effect means that they may not be opposed to the FCGH proposal per se but only attempt to draw attention to possible weaknesses that need to be addressed in formulating the idea.

On the duplicating effect, it is argued that various international treaties already address the concerns that would be addressed by the proposed FCGH. According to Hoffman and Røttingen (2013), forming new legal frameworks, structures and new obligations would undermine existing initiatives. Yet, “in addition to the usual inefficiencies of duplication and fragmentation, regime complexity can make it more difficult to locate political authority, identify who is making which policies, and figure out how to hold deciders accountable for their decisions”.

To this they add that the FCGH may also undermine global governance more broadly by diluting the power of existing institutions, weaken international legal obligations by increasing contradictory mandates, and diminish compliance with them by raising administrative burdens and transaction costs.

The issue of the possible lack of feasibility rotates around the question of the costs the convention, both in terms of negotiating an agreement and implementing it thereafter. Hoffman and Røttingen (2013) fear that political agreement would also be difficult to achieve. The author further fear that some of the most powerful actors and institutions “including the Global Fund to fight HIV/AIDS, malaria and TB, and the Bill and Melinda Gates Foundation as well as the WHO may perceive the proposed Convention as a threat to their strategic interests and may obstruct it”.

Yet, this fear may be unfounded as UNAIDS, which brings together UN agencies (including WHO) in the fight against HIV, has already endorsed the FCGH idea in a gesture of a vote of confidence that could be followed by other influential institutions as the FCGH movement gains momentum.

On the issue of the questionable impact, Hoffman and Røttingen (2013) argue that the FCGH proposal does not address several fundamental challenges in global governance for health, such as the democratic deficit in global decision-making, political accountability, cross-sectoral interdependence, and institutional fragmentation, and regime complexity. And that “barriers to realizing the right to health lie primarily at the national level, such that new international laws, which are notorious for being ignored and remaining unfulfilled, would lack sufficient carrots or sticks to achieve impact commensurate with its costs” (Hoffman and Røttingen, 2013).

It has, however, been noted that the existing framework has a number of faults and some of these faults have been the basis of voices opposed to the FCGH proposal. For instance, it is indicated that the right to health as crafted in the current international human rights regime is inadequate in “addressing extremely poor health” and “detrimental reliance on gradual steps of ‘progressive realization’ and inadequate mechanisms for implementation and enforcement” (Gable and Meier (2013).

Other problems facing current mechanisms have been identified to include: ignorance of the treaty provisions and processes; failure to create national vehicles for implementation; failure to produce state reports; failure to remove impermissible reservations; substantive inadequacy of state reports; failure by the treaty bodies to consider reports submitted in a timely manner; lack of access to reliable, comprehensive information by the treaty bodies; inadequate concluding observations; failure to follow-up concluding observations and views on communications; and failure to encourage individual complaints (Gable and Meier, 2013).

Gable and Meier (2013) have noted other weaknesses to be: failure to professionalize the complaint process; lack of resources for the treaty bodies and their secretariat; duplication and lack of coordination among treaty bodies; lack of coordination and streaming of individual cases within OHCHR; lack of information-sharing or exchange on country situations between the treaty bodies and elements of OHCHR as well as other UN actors; lack of expertise and independence of treaty body members; wide discrepancy in the actual degree of engagement by states in the treaty system and a negative backlash from those actively involved.

Additionally, the human rights regime is found not to address issues of global health governance and the responsibilities of states toward global health. It is against the background of these weaknesses that proposals have been made for the FCGH to address the following questions:

What are the essential services and goods guaranteed to every human being under the right to health;

- What is the responsibility that all states have for the health of their own populations;
- What is the responsibility of all countries to ensure the health of the world's population; and
- What kind of global health governance is needed to ensure that all states live up to their mutual responsibilities.⁴

⁴ As above, at 21 – 2.

The Convention is also expected to deal with other factors that indirectly affect health such as intellectual property rules which hinder access to medicines. Other issues would be environmental issues like deforestation and other activities that lead to climate change. These are matters that are not addressed within the right to health legal regime.

At the same time, some arguments have been made to discredit the need for the FCGH. Some opponents have expressed fear that the Convention would simply be creating another treaty and adding to the already weak international law. The assumption that law has the potential to change the status quo has been challenged. Oona Hathaway (2002) wonders whether human rights treaties are really complied with, and if at all they have an effect on state behaviour.

Steven Hoffman and John-Arne Røttingen (2013) have alluded to some of the possible shortcomings of the proposal for the FCGH. Their arguments are grounded on three issues: duplicating effect; possible lack of feasibility; and questionable impact. However, the authors indicate that their objective is to set out concerns that need to be addressed, which in effect means that they may not be opposed to the Convention but are mindful of weaknesses which require attention.

On the duplicating effect, it is argued that various international treaties already address the concerns that would be addressed by the proposed FCGH. According to Hoffman and Røttingen, forming new legal frameworks, structures and new obligations would undermine existing initiatives. Yet, "in addition to the usual inefficiencies of duplication and fragmentation, regime complexity can make it more difficult to locate political authority, identify who is making which policies, and figure out how to hold deciders accountable for their decisions".

To this they add that the FCGH may also undermine global governance more broadly by diluting the power of existing institutions, weaken international legal obligations by increasing contradictory mandates, and diminish compliance with them by raising administrative burdens and transaction costs (Hoffman and Røttingen 2013).

The issue of the possible lack of feasibility rotates around the question of the costs the convention, both in terms of negotiating an agreement and implementing it thereafter. Political agreement would also be difficult to achieve (Hoffman and Røttingen 2013). It is argued that some of the most powerful actors and institutions “including the Global Fund to fight HIV/AIDS, malaria and TB, and the Bill and Melinda Gates Foundation as well as the WHO may perceive the proposed convention as a threat to their strategic interests and may obstruct it” (Hoffman and Røttingen 2013). Yet, at the same time it is illustrated that the endorsement of the FCGH proposal by UNAIDS is an indication of support from powerful institutions.

On the issue of the questionable impact, it is argued that the FCGH proposal does not address several fundamental challenges in global governance for health, such as the democratic deficit in global decision-making, political accountability, cross-sectoral interdependence, and institutional fragmentation, and regime complexity (Hoffman and Røttingen 2013). Yet, “barriers to realizing the right to health lie primarily at the national level, such that new international laws, which are notorious for being ignored and remaining unfulfilled, would lack sufficient carrots or sticks to achieve impact commensurate with its costs” (Hoffman and Røttingen 2013).

Nonetheless, in the case of the relevance of the FCGH to Uganda, it is important to examine the extent to which Uganda has protected the right to health and some of the challenges which the health sector in Uganda is facing. One would then examine the extent to which some of the proposals for the FCGH would address some of these challenges.

3. THE POLICY AND LEGAL FRAMEWORK AND THE RIGHT TO HEALTH

SUMMARY

Uganda is a dualist country, which in principle requires that international treaties are domesticated and incorporated into national law before becoming law applicable in the domestic context

BUSINGYE 2010

A discussion of the extent to which the right to health is protected within Uganda's policy and legal framework needs to be understood against the background of the international legal standards governing this right. This is because Uganda has committed itself to these standards by ratifying various treaties which protect the rights.

Although it is strictly speaking not a treaty, the Universal Declaration of Human Rights (UDHR)⁵ guarantees the right to a standard of living adequate for health and wellbeing, and specifies the elements of this to include food, clothing, housing and medical care and necessary social services. This is in addition to the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond one's control (Article 25(1)). The UDHR guarantees motherhood and childhood special care and assistance (Article 25(2)).

In the same manner, the International Covenant on Economic, Social and Cultural Rights (ICESCR) guarantees the right to an adequate standard of living and includes in it the same elements as the UDHR, although it excludes medical care in defining this right (Article 11).

⁵ Adopted and opened for signature, ratification and accession by General Assembly Resolution 2200A (XXI) of 16 December 1966, entry into force 3 January 1976.

However, in a more specific manner, the ICESCR guarantees the right to the enjoyment of the highest attainable standard of physical and mental health (Article 12(1)).⁶ The obligations of the state in relation to this right are defined to include the provision for the reduction of the still-birth-rate and of infant mortality and for the healthy development of the child; improvement of all aspects of environmental and industrial hygiene; prevention, treatment and control of epidemic, endemic, occupational and other diseases; and creation of conditions which would assure to all medical service and medical attention in the event of sickness.⁷

One could also argue that the ICESCR focuses on the obligations of individual states and not on global obligations. Although the ICESCR imposes the obligation of international co-operation, this obligation has largely remained contested, and where assistance has been provided, this has not been viewed as an obligation.

It is from this perspective that the advocates of the FCGH have chosen to use the term “global health”. WHO has defined the term “global public health” by recognizing the fact that as a result of globalization, forces that affect public health can and do come from outside state boundaries and that responding to public health issues now requires attention to cross-border health risks, including access to dangerous products and environmental change.⁸

⁶ Article 12(1).

⁷ Article 12(2). Like other rights guaranteed by the ICESCR, the Committee on the Economic, Social and Cultural Rights (UNCESCR Committee) has through one of its general comments elaborated on the substantive and normative content of this right; spelling out the state obligations it gives rise to and how these are to be discharged. See UNESCR Committee General Comment No. 14 The Right to the Highest Attainable Standard of Health (Adopted by the Committee at its 22nd Session, 2000).

⁸ See <http://www.who.int/trade/glossary/story076/en/> (accessed on 22 August 2014).

From a conceptual perspective, the term has been defined as an area for study, research, and practice that places priority on improving health and achieving equity in health for all people worldwide. It has been argued that global health emphasizes transnational health issues, determinants, and solutions; involves many disciplines within and beyond the health sciences and promotes inter-disciplinary collaboration; and is a synthesis population- based prevention with individual-level clinical care (Battams and Matlin).

At the African regional level, the right to health is in the first place protected by the African Charter on Human and Peoples' Rights (ACHPR) as seen in Article 16 of the Charter. Other regional instruments including the African Charter on the Rights and Welfare of the Child (ACRWC) guarantee children the right to the best attainable standard of mental and physical health (ACRWC, Article 14).

This is in addition to the Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa (African Protocol on Women) guarantees women the right to health, which it defines to include sexual and reproductive health (Article 14).

It is from the above perspectives and context that the efficacy of the FCGH in enhancing health in Uganda should be discussed. This is more so because of the fact that Uganda is internationally obliged to domesticate and implement the international standards highlighted above. Thus, the shortcomings of the international regime have a bearing on the effectiveness of the domestic regime.

3.1 The extent of the right in Uganda

Uganda is a dualist country, which in principle requires that international treaties are domesticated and incorporated into national law before becoming law applicable in the domestic context (Kabumba Busingye 2010). It should be noted that Uganda maintains good international visibility by taking part in international events, signing and ratifying treaties and endorsing international declarations, resolutions, guidelines and other instruments. In spite of this, the country is fairly slow when it comes to domesticating the international legal standards and giving them domestic legal force. This could be explained by both sheer sluggishness and by the slow pace of legislative processes in the country.

Nonetheless, in some cases one finds principles arising from international instruments scattered in various laws and could be used to determine the extent to which the international standards are indirectly domesticated.

Indeed, Uganda is not short of laws, standards and policies which govern different aspects of health and ones which if effectively implemented would go a long way in improving the health of Ugandans. Unfortunately, there is a divergence between legal standards and their actual implementation. While the country has ratified several international treaties, few have been domesticated.

On a positive note however, this is something which is changing, with the country gradually acting to domesticate international instruments; there is growing reference to international instruments in policies, programs and draft laws.⁹ This can also be attested by the seriousness with which Uganda took the United Nations Human Rights Council Universal Periodic Mechanism (UPR).¹⁰

⁹ See reference to international obligations in HSSP III and the NHSP II. See also the Narcotics and psychotropic substance control Bill, which expressly states that its objective is to domestic United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances

¹⁰ See United Nations Office of the High Commissioner for Human Rights A National

If effectively domesticated and implemented, the international and regional standards mentioned above would enhance the state of health in Uganda.

Nonetheless, there are some weaknesses in the country's legal framework pertaining to the right to health, which have among others resulted from the failure to fully domesticate the international standard. From a human rights perspective, the right to the highest attainable standard of health is not expressly protected in the country's Bill of Rights. However, elements of the right can be pieced from parts of the Constitution and other provisions of the law. The emphasis within the Bill of Rights has been put on civil and political rights, ESCRs are only scantily protected in the Bill of Rights, though a bulk of ESCRs elements are part of the National Objectives and Directive Principles of State Policy (NODPSP) contained in the Constitution.

Specific provisions in the Bill of Rights which expressly protected elements of ESCR include Article 33(3), which provides as follows:

33. Rights of women

(1) ...

(2) The State shall protect women and their rights, taking into account their unique status and natural maternal functions in society

Equally relevant is Article 34(3) which provides thus:

34. Rights of Children

(1) ...

(3) No child shall be deprived by any person of medical treatment, education or any other social or economic benefits by reason of religious or other beliefs

Article 35 guarantees PWDs the right to respect and human dignity and requires the state to take appropriate measures to ensure that PWDs realize their full mental and physical potential. Article 39 guarantees every Ugandan the right to a clean and healthy environment. Equally important is Article 24 which prohibits torture or cruel, inhuman or degrading treatment or punishment.

While Article 45 provides for an omnibus protection of human rights in its provision that the rights, duties, declaration and guarantees relating to human rights specifically mentioned in Chapter Four do not exclude others not specifically mentioned. This provision creates room for one to read a wide range of ESCRs deriving from international human rights law into the provisions of Uganda's laws. Article 245 requires Parliament to make laws for to protect and preserve the environment from abuse, pollution and degradation, to manage the environment for sustainable development, and to promote environmental awareness.

As indicated, the NODPSP have several elements of the right to health. Objective XIV requires the state to endeavour to fulfil the fundamental rights of all Ugandans to social justice, by among others ensuring that all Ugandans enjoy rights and opportunities and access to education, health, services, clean and safe water, work, decent shelter, adequate clothing, food security and retirement benefits.

In Objective XX the state has to "take all practical measures to ensure the provision of basic medical services to the population". While in Objective XXI the state is expected to "take all practical measures to promote a good water management system at all levels". Equally so, Objective XXII(b) requires the state to "encourage and promote proper nutrition through mass education and other appropriate means in order to build a healthy State". In the same vein, Objective XXVII has obligations related to maintaining the environment.

One would have expected the judiciary to build on the above activist approach and to find protection for the right to health.

Unfortunately, the judiciary has not taken full advantage of the above provisions to legally entrench the right to health. Although the case is still the subject of an appeal, the case of Centre for Health, Human Rights and Development¹¹ is an example of this failure.

This case arose out of the death of labouring mothers due to negligence and neglect by medical staff, in addition to the absence of medical facilities. In the case, the Petitioners argued that the failure of the state to ensure that the facilities and supplies exist at health care facilities with proper services was a violation of the Constitution. In particular, it was a violation of the right to life, rights of women and the right to health as can be deduced from the NODPSP and other provisions.

Unfortunately, the Constitutional Court declined to adjudicate this matter, concurring with the state that the case raised political questions which by virtue of the political question doctrine barred the courts from hearing such cases. According to the Court, the case raised policy issues in the domain of the other organs of the state by virtue of the doctrine of separation of powers. Until the Supreme Court reverses this decision, the justiciability of ESCRs hangs in balance in Uganda.

In addition, the country's recent legislative approach has resulted in the adoption of laws which in effective undermine the right to health. An example is the recently promulgated HIV Prevention and Control Act, which among others criminalises the spread of HIV/AIDS, which could potentially discourage people from being tested.

¹¹ Constitutional Petition No. 16 of 2011

The recently nullified Anti-Homosexuality Act too had negative implications on health by criminalising same-sex relationship, which would discourage people in same-sex relations from seeking medical assistance.¹² This approach, and other challenges afflicting the health sector, make it hard to fully realise the right. Some of the challenges are discussed in the following sub-section.

The above legal approaches have failed to build a framework that could among others use the law to deal with some of the challenges the health sector is facing. The law has failed to build a framework and defined legal standards that could be used to hold the Government accountable and empower citizens to claim their rights. It is from this standpoint that the challenges which the health sector is facing should be examined. This does not however mean that civil society and other stakeholders are not engaging with these challenges. Indeed, in many cases the law is being stretched and courts pushed to recognise the right to health.

12 See decision of the Constitutional Court in Prof Joe Oloka-Onyango & Ors vs Attorney General, Constitutional Petition 08 of 2014.

4. CHALLENGES FACING UGANDA'S HEALTH SYSTEM

SUMMARY

80% of pharmacists and 40% of nurses are based in urban areas, which have only 12% of the country's total population

**UGANDA COALITION ON ESCRS,
2014**

A Parallel Report prepared by the Uganda Coalition on Economic, Social and Cultural Rights and submitted to the UN Committee on Economic, Social and Cultural Rights in response to Uganda's Initial States Report profiles some of the challenges the health sector is facing.¹³

The challenges in the country's health sector are summarised to include: a legal framework that does not guarantee the right to health and has laws which have negative public health implications; a health care budget which is highly dependent on donor support, allocations to the sector not being consistent with international and regional obligations and funds being mis-managed; staff inadequacies, especially in rural areas; stock-outs of essential medicines and health care services affected by poor infrastructure; unacceptably poor reproductive health care standards, exacerbating the problem of maternal mortality; increasing HIV/AIDS infection rates which are reversing gains scored;

¹³ See Alternative Report of The Uganda Coalition on Economic, Social and Cultural Rights to the 53rd Session of The Committee on Economic, Social and Cultural Rights on Uganda's Initial Report (September 2014).

high levels of maternal death and health complications arising from unsafe induced abortions; and the lack specialised mental health care personnel.

The inadequacies in the legal policy are not only with respect to the right to health but, as indicated above, pertain to all ESCRs. One interesting thing to note though is the fact that some of the Government's policies and programmes conceptualise health as human rights issues and in some cases even proclaim the right to health. Examples of such policies include the National Health Policy II (2010-2020) (Ministry of Health 2010), in addition to the Health Sector Strategic Plan III (HSSP III).¹⁴ However, as illustrated above, the laws do not recognise the rights, which have made it hard to claim the right as a legal entitlement.

Inadequate budgetary allocations to the Health Sector not only nurture but also compound the other challenges. The allocations are far below the country's international commitments, which includes commitments in the African Union Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases to allocate at least 15% of the national budget to the sector.¹⁵ The country has not even met its own domestic commitments, which include targets set in HSSP III at 9%.

14 The Republic of Uganda, Ministry of Health, Health Sector Strategic Plan III, 2010/11 – 2014/15

15 OAU/SPS/ABUJA/3, Adopted by the African Union Special Summit of Heads of State and Government, 26 – 27 2001, Abuja, Nigeria.

Worryingly, the allocations have, in a retrogressive manner, been reducing with each budgetary allocation: moving from 8.9% in 2010/2011 to 8.4% in 2011/2012 and further down to 7.4% in 2012/2013 (Ministry of Health 2013). One irony though, as illustrated in the Parallel Report, is that amidst these budgetary shortfalls the country is facing fund absorption challenges. One of the areas where this is visible is in drug procurement and distribution. The example is given of drug stock-outs, yet money allocated to the National Medical Store (NMS), as was the case in 2009/2010, is sometimes returned to the treasury as unutilized funds. This has been attributed to the problem of poor planning by ministries and inadequate specifications of output, in addition to procurement related challenges.

Relating to budgeting is the fact that much of the funding in the sector is donor dependent. In 2012, for instance, over 40% of the health budget was dependant on donor funds. Additionally, the budget and finance monitoring mechanisms in place throughout the country are poor. The Ministry of Health (MoH)'s oversight of the financial information for general and regional hospitals is weak, apparently relying on submission of reports for the purpose of drafting the Annual Health Sector performance Report (AHSPR).

Only 54 of 113 general hospitals and only 8 of 13 regional referral hospitals returned reports with complete financial data.¹⁶ MoH has not prioritized analysis of efficiency and use of funds, and must be more active in pursuing and publishing this information in order for the health sector to thrive.

The country also faces serious human resource and staffing challenges in the sector, which are far below the levels recommended by international standards. In sum, human resource recruitment, utilization and development have been mismanaged: low wages, poor health infrastructure, heavy workloads, and the lack of suitable accommodation make recruitment and retention of medical staff problematic. Most affected are upcountry locations, with many districts having as much as 67% of positions vacant. It has been reported that 80% of pharmacists and 40% of nurses are based in urban areas, which have only 12% of the country's total population.¹⁷

The problem of stock-outs of essential medicines persists, in spite of the budget of NMS being increased. Ironically, sometimes medicines at NMS expire when some districts are facing stock-outs of the same medicines. This has been attributed to delays in procurement, poor quantification, late orders, poor record keeping and theft of medicines and medical equipment. Some health facilities also lack the capacity to store certain types of medicines or to even effectively transport the same in cases of emergency.

In the area of HIV/AIDS, Uganda is on record as one of the countries which scored success in reversing the spread of the epidemic. One of the areas where challenges are being faced though is ensuring access to ARV treatment for persons living with HIV/AIDS. The Parallel Report indicates that close to 40% of those living with AIDS are not accessing ARV treatment.

16 Draft MOH AHSPR FY 2009/2010, pg 134, 137

17 The Parallel Report makes reference to the Ministry of Health's Human Resource for Health Audit (May 2009).

Yet, worryingly, the number of new infections is increasing. The Uganda Aids Commission is for instance quoted as indicating that infections increased by 11.4% between 2007/8 and 2009/10, which made Uganda the country with the fourth highest infection rate (UAC 2012). Access to ARV treatment is explained among others by the misappropriation of resources meant for treatment and the lack of capacity on the part of some health centres to administer the treatment.

There are also serious challenges in ensuring access to reproductive health, which have among others made it impossible for Uganda to meet the target of reducing maternal mortality as contained in MDG 5 on improving maternal health through reduction by three quarters of the maternal mortality ratio and ensuring access to universal reproductive health by 2015. As indicated above, maternal mortality per 1000 live births in Uganda has reduced only from 506 in 1995 to 438 in 2011 and the country is unlikely to achieve the target of 131 in 2015.

Factors which have been identified as being responsible for this include understaffing of health care facilities, lack of medicines and medical equipment necessary for safe delivery, and preference for traditional birth attendants by some mothers. Access to emergency obstetric care also remains a problem for many mothers, as is access to contraception, which results into unexpected and unplanned pregnancies. Induced abortions also remain a big problem, resulting mainly from lack of access to safe abortion services due among others to the constraining legal framework.

Health care infrastructure remains poor at many health facilities, with many lacking such basic utilities as water and electricity. Many facilities have dilapidated buildings and lack infrastructure to accommodate inpatients and provide accommodation for medical personnel. As regards, mental health, the biggest challenge is the lack of medical staff in this area. Uganda has a psychiatrist patient ration of 1:2,500,000 and yet only 1% of the country health care budget is committed to mental health care (Ntulo et al. 2008).

5. RELEVANCE OF THE FCGH

SUMMARY

While retaining its autonomy, Uganda will reap the benefits of a more coordinated global health governance system which is likely to streamline health care resources and direct them to addressing inequities between Uganda and other countries

ANALYSIS

It could be argued that the advocacy which will characterise the processes leading to the adoption of the FCGH would go a long way in putting pressure on the state to protect the right to health. This would help overcome the minimalist approach which has seen many countries including Uganda decline to guarantee the right as a constitutional right. It is for this reason that a suggestion has been made that the processes of advocating for the FCGH should be driven by a strong global social movement around the right to health” (Haynes 2013).

For this reason, it would be important that Uganda CSOs working on issues in the health sector begin preparing themselves to be part of this global movement. It has been cautioned though that such global campaign should not be structured around “abstract and distant reforms” but should rather be focused on the priorities of communities, finding a direct response to those problems and offering real access to the levers of change (Haynes 2013).

The multi-disciplinary approach suggested by the advocates of the FCGH would reduce reliance on the legal approach to realise the right, which in the case of Uganda has up to now not achieved much. For instance, as indicated by Asbjørn, relying on courts can often be costly, time-consuming and frustrating (Asbjørn 2011). It could indeed be argued that reliance on the legal approach to realise the right is the lesser way. One should instead use a multi-disciplinary approach, but one which would still use the legal approach as part and parcel of other measures.

Furthermore, the campaign for the FCGH, as argued by Haynes et al, is likely to have an impact on global responsibility for global health (Haynes 2013). This would arise from the approach which it is suggested the FCGH adopts, which in effect recognises “[i]nternational aid for health care ... as an obligation arising from global solidarity rather than as an instrument for achieving global stability and national security” (Haynes 2013).

This would be in line with the recently adopted Maastricht Principles on the Extra-Territorial Obligations of States in the area of Economic, Social and Cultural Rights. These principles, which were adopted in 2011 by a group of experts in international law and human rights, emphasise the point that states have human rights obligations beyond their territories (Schutter 2012).

These Principles indicate that a State has obligations to respect, protect and fulfill economic, social and cultural rights in situations over which it exercises authority or effective control, whether or not such control is exercised in accordance with international law in the following situations: where State acts or omissions bring about foreseeable effects on the enjoyment of economic, social and cultural rights, whether within or outside its territory; where the State, acting separately or jointly, whether through its executive, legislative or judicial branches, is in a position to exercise decisive influence or to take measures to realize economic, social and cultural rights extra-territorially, in accordance with international law.¹⁸ One challenge though is that these principles have not been endorsed by states and are some cases rejected.

If the obligations defined by the Principles are embraced and defined within the FCGH and states make commitment to them, they would go a long way in helping countries such as Uganda overcome the financial and technical challenges they have by getting assistance from other states.

To understand the relevance of the FCGH to Uganda, it is important to look at some of the benefits which advocates have argued would flow from the Convention, and some of which could help in determining its content. The benefits of the FCGH have been described by JALI's FCGH Platform to include the following:¹⁹

- Create a right to health governance framework;
- A global health treaty based on the right to health and aimed and closing national and global health inequities;

18 ETO Principles, Principle 9.

19 See <http://www.globalhealthtreaty.org/>

- Provide standards to ensure health care and underlying determinants of health, such as clean water and nutritious food, for all, along with an international and domestic financing framework to secure sufficient, sustained funds, while addressing the social determinants of health;
- Establish a transformative understanding of the right to health to create the accountability now missing, and adapt the right to the globalized world;
- Establish pathways towards national and global health equity, with a special concern for marginalized populations, and further inclusive and democratic decision-making on health and related concerns, domestically and internationally.
- Clearly define extraterritorial obligations, while ensuring that policies in other sectors are responsive to public health needs, including by elevating the status of health and demanding adherence to the right to health in other international legal regimes, such as trade and investment;
- Promote strong domestic accountability mechanisms and an effective compliance framework for the FCGH itself, including innovative incentives and sanction;
- Would help achieve expected elements of the Sustainable Development Goals such as universal health coverage and ensuring for all clean water, adequate sanitation, nutritious food, and other underlying determinants of health; and
- Would provide a bold vision of universal health coverage rooted in equality, where the level of care does not depend upon a person's wealth, and coverage is not limited to a basic package of services or unduly constrained by a narrow vision of available resources.

From the above perspective, the FCGH would have the potential of addressing some of Uganda's health challenges indicated above. It has been argued that the governance framework envisaged would be able to synchronize the increasing fragmentation of global health governance but while at the same time preserving creative diversity and local autonomy (Brolan et al. 2013).

In the case of Uganda, while retaining its autonomy, the country would reap the benefits of a more coordinated global health governance system which is likely to streamline health care resources and direct them to addressing inequities between Uganda and other countries. Yet, the governance system proposed would establish systems that can be used to manage the resource constraints which the current system is facing and which in some cases arise from uncoordinated funding of the sector. This could, among others, be used to ensure that access to quality health care services is universal, and, as indicated above, access does not depend on one's wealth.

Nonetheless, such governance and coordinated funding would do little to overcome the systemic challenges which Uganda faces as a country, and especially if not much is done to establish mechanisms that help to manage the polycentric problems which countries face. It is therefore important that the governance structure suggested by the FCGH while being broad enough and giving countries autonomy should establish a system of global support to help countries improve their governance, and moreover, in a less bureaucratic manner. The accountability system established by the FCGH and the entrenchment of the right to health could help to force countries such as Uganda to be more responsible to the needs of their population.

It has, for instance, been argued that the FCGH could establish accountability around well-defined obligations for the social determinants of health, at the least creating obligations to give force to Health in all Policies and advancing the “do no harm” principle embedded in the right to health, respecting this right in all contexts. That the treaty could creatively intersect with international law in other sectors to ensure a higher priority for the right to health and would strengthen a bottom-up mode of global governance that involves local, regional, and global social movements into setting the agenda, implementing, and monitoring health politics and health policies.²⁰

Although the above may not overcome Uganda’s health related challenges in a short period of time, the FCGH would in addition to rejuvenating advocacy on health related issues be the start of building a global system that is more mindful of reducing health inequity. This would result to making health challenges a global problem requiring global approaches, with mainly such poor countries as Uganda benefiting and being part of global health decision-making.

20 Platform for a Framework Convention on Global Health: Realizing the Universal Right to Health Fundamental Principles and Joining the Platform (May 2014), available at <http://www.globalhealthtreaty.org/docs/platform-for-an-fcgh-full.pdf> (accessed on 4th October 2014).

6. CONCLUSION

SUMMARY

The extra-territorial obligations towards global health proposed to be put in place by the FCGH will put countries like Uganda in a position to harness and benefit from the resources and expertise which is available at the global level.

CONCLUSION

This paper has looked at the proposal for a FCGH as a possible solution to the most perplexing problems in global health. These problems are so significant that they affect the destiny and fate of millions of people globally, every single day. Examples of challenges in the health sector, both at the global and domestic levels, include funding and health governance systems that are incapable of directing health resources to where they are needed most and ensuring equitable access to services.

There has also not been sufficient coordination to ensure that all determinants of health are promoted in ways which are holistic and sustainable. Indeed, one of the things which have emerged from the discussion on the FCGH is that no state acting in isolation can detach itself from the grip of the major health hazards; which means that safeguarding the world's poor and sick might need global action but while at the same time strengthening domestic systems and supporting them to enhance their capacity.

As evidenced by the discussion on the legal and policy framework of the right to health, it is very clear that there are a number of laws in Uganda (and surely even regionally and globally) that are available to states to en-

sure the promotion, protection and fulfilment of not only the right to health but also all the other fundamental rights and freedoms. The major problem facing Uganda and the entire human rights community is the failure to implement what is in theory guaranteed. The implementation of the existing laws has been undermined by resource challenges and the absence of effective governance systems within which they could be implemented.

The proposals for the FCGH have called for an approach which would in addition to using a rights framework embrace a considerable scope of issues. This includes a wide range of social and other determinants of health, while at the same time addressing health inequities both within and between countries. This would go a long way in alleviating the limitations of the current legal framework. The processes leading to discussions and eventual adoption of the Convention would also enhance global and country based advocacy to promote health, which could bolster the work of the various CSOs working on different health issues. Uganda is not an exception in this regard.

The extra-territorial obligations towards global health proposed to be put in place by the FCGH will put countries like Uganda in a position to harness and benefit from the resources and expertise which is available at the global level. It has for instance been argued that the treaty could enable predictable international resources aligned with national strategies, with accountability at country and community levels. This is in addition to providing a framework for improved budget tracking, evaluation, and accountability, including through participatory budgeting.

Further, the advocacy and social activism around the process leading to the adoption of the Convention will highlight challenges in the sector, and if carried out using an approach that focuses on community needs, will go a long way in advancing health wellbeing in Uganda.

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