BEYOND SOCIAL PROGRAMMES:

Protection of the Right of Access to Malaria Treatment in Uganda.

Ben Kiromba Twinomugisha

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SUMMARY OF THE PAPER

Malaria is a significant health problem in many countries of Africa, including Uganda where it has caused enormous suffering and economic losses. It is a leading cause of mortality and morbidity. There are between 70,000 and 110,000 deaths yearly as a result of malaria and 25-40% of all outpatient visits and 9-14% of inpatient visits are malaria related. The socio-economic burden of malaria is enormous. Malaria contributes to lost life and productivity. An estimated 23.4% of total discounted life years are lost. Malaria severely impacts on the ability to work and causes absenteeism from school. Malaria is both a cause and a consequence of poverty and its impact is more severely felt by the poor who are unable to afford preventive measures and medical treatment. In Uganda, there have been various programmes to tackle malaria. Through the Health Sector Strategic Plan and the Uganda Malaria Control Strategic Plan (UMCSP), the Ministry of Health has prioritized areas of intervention including: 1) improving the case management of clinical malaria through artemisinin-based combination therapy (ACT) delivered at health facilities as well as at the community/household level through home based management of fever (HBMF) and 2) malaria prevention using a combination of insecticide treated nets (ITN) and indoor residual spraying. Against this background, this working paper teases out the extent to which the legal and policy frameworks related to the fight against malaria enhance or inhibit protection of the right to health generally and the right of access to malaria treatment in particular. The paper also explores the modalities through which the relevant actors can be held accountable for violations of the right under inquiry.

The right to health generally and the right of access to malaria treatment in particular, have a firm foundation in international, regional and domestic contexts. Although Uganda has tried to provide access to malaria treatment, it has not met all its obligations as laid down in international instruments. Neither the Uganda Constitution nor any legislation expressly provides for the right to health and its various components.

Despite the absence of a solid legal context for addressing the issue, the state should be commended for developing a policy framework that targets vulnerable groups such as pregnant women and under-five children. However, the policy framework neglects other individuals or groups who are unable for reasons beyond their control to realize the right by means at their disposal. The policy framework does not indicate how the state intends to tackle inequitable gender relations that may inhibit women, especially from rural areas, from accessing malaria treatment. The policy framework does not include strategies of ensuring that the ACT regimen is accompanied by necessary nutrition. The framework also lacks mechanisms for the involvement of Traditional Birth Attendants (TBAs) and other traditional healers in the management of uncontrolled

malaria. Furthermore, the framework lacks modalities through which people at the grassroots can participate in the design, implementation, monitoring and evaluation of malaria related policies and programmes. It is also true that the framework does not take into account the impact of the patent regime on the realization of the right of access to malaria treatment.

This paper recommends that a Rights Based Approach (RBA) should guide policy makers and implementers in the prevention and treatment of malaria. They must also incorporate a gender perspective into the design and implementation of interventions on malaria control. The state should provide adequate resources to enable timely procurement of anti-malaria drugs. This requires increased funding for the health sector up to 15% of the national budget as recommended by the Abuja Declaration. There is also a need to tackle corruption in the health sector by labeling government procured drugs to ensure that they do not end up in private clinics. To alleviate the prospects for corruption and generally to curtail the brain drain in the health sector, the remuneration and other working conditions of health workers must be improved. There is a need for raising awareness on the implications of policy on human rights in general and on the right to health in particular among legislators, judges, human rights commissioners, pharmaceutical companies and civil society. Uganda must regularly report on the progress it has made in realizing the right to health and its various components such as access to malaria treatment. Any difficulties encountered in the implementation of its obligations in this regard must be candidly admitted and comprehensively addressed. Given that Uganda has insufficient manufacturing capacity, it should adopt a regional approach to the use of the flexibilities in the Trade Related Aspects of Intellectual Property Rights (TRIPS) regime.

At the juridical level, there is an urgent need to explicitly recognize the right of access to health care in the Bill of Rights of the Constitution. There is also a need for a framework legislation that lays down obligations in the area of the prevention and treatment of malaria. Such legislation should domesticate all the international and regional instruments that recognize the right to health which Uganda has ratified. Public-spirited individuals and Civil Society Organizations (CSOs) should, through litigation, challenge actions or omissions that negate the right to health and its components.

I. WEIGHING THE BURDEN OF MALARIA IN UGANDA

Malaria, a parasitic disease transmitted through the bite of a female anopheles mosquito, is a significant health problem in Africa. Over 80% of malaria deaths occur in Africa.[1] Like in many other malaria endemic countries, malaria is a leading cause of morbidity and mortality and has caused enormous human suffering, death and economic losses in Uganda. There are approximately between 70,000 and 110,000 deaths yearly as a result of malaria and 25-40% of all outpatient visits and 9-14% of inpatient deaths are malaria related.[2] There are between 11% and 23% of deaths among under-fives in medium and high malaria transmission areas respectively.[3] The most severe forms of malaria cause organ failure, delirium, impaired consciousness and generalized convulsions, followed by death.[4] A large number of pregnant women living in malaria endemic areas are anemic and regularly suffer from severe complications such as stillbirths and miscarriages. Many children are hospitalized from malaria than from any other single disease, which may affect their subsequent physical and mental development. The disease causes childhood anemia, reduced growth (stunting), and mental retardation.[5] Thus, malaria significantly contributes to child and maternal mortality in Uganda. The Maternal Mortality Ratio (MMR) is at 435 per 100,000 births while the Infant Mortality Ratio (IMR) is at 88 per 1000 births.[6]

The socio-economic burden of malaria is enormous. Malaria contributes to lost life and productivity. An estimated 23.4% of total discounted life years are lost.[7] This is because the weakness caused by the disease in adults can severely impact their ability to work thus leading to loss of earnings. Families spend their meager earnings on malaria treatment.[8] Malaria also causes absenteeism from school, thus affecting the child's right to education.[9] It is estimated that in malaria endemic areas like Uganda, the disease may impair up to 60% of the school children's learning ability.[10] According to the Poverty Eradication Action Plan (PEAP)[11] and the Health Sector Strategic Plan (HSSP)[12] malaria is a leading cause not only of ill health and death but also of poverty in Uganda. Poverty levels are currently at 31% although in Northern Uganda over 60%

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[1] World Bank, 2005.
[2] USAID, 2006.
[3] Ministry of Health 'The Burden of Malaria in Uganda', available at http://www.health.go.ug/malaria.htm, accessed on April 17, 2008.
[4] Id.
[5] Id.
[6] UBOS, 2006.
[7] Ministry of Health, note 3.
[8] For example, in Kabarole and Bundibugyo districts, the direct cost of treatment for an episode of suspected malaria averages shs. 4,500, and shs. 2,000 in rural populations (Ibid.).
[9] Article 30 of the 1995 Constitution.
[10] Id.
[11] MFPED, 2004. The PEAP was first developed in 1997 and has been revised twice, in 2001 and 2004. The PEAP has five pillars, namely, 1) economic management; 2) production, competitiveness and incomes; 3) security, conflict resolution and disaster management; 4) governance; and 5) human development.
[12] Ministry of Health, 2005a.

live below the poverty line.[13] Like in many other countries of Africa, many poor people have no access to modern health care services, including malaria treatment.[14] Uganda loses at least $ 690 million to malaria every year.[15] This makes fighting malaria, in line with the Millennium Development Goals (MDGs) a top priority.[16] The MDGs enjoin states to eradicate poverty and to combat HIV/AIDS, malaria and other diseases. Paul Hunt, the UN Special Rapporteur on the right to the highest attainable standard of health has aptly summarized the impact of malaria as follows:

> *Malaria is both a cause and consequence of poverty. Its impact is essentially ferocious on the poorest: those least able to afford preventive measures and medical treatment. The impact is not only felt in terms of avoidable human suffering and death but economic cost and burden.*[17]

There have been various programmes at the international level to tackle malaria. For example, in 1998 the World Bank and its international partners—World Health Organization (WHO), United Nations Development Programme (UNDP), and UNICEF—announced a "Roll-Back Malaria" initiative intended to cut malaria in half in 12 years.[18] In 2005, President Bush announced a US$1.2 billion initiative to fight malaria in 15 African countries including Uganda.[19] The Global Fund to fight HIV/AIDS, Tuberculosis (TB) and Malaria was also established. Of the money committed, 61% of this fund is to be spent in Sub-Saharan Africa. Out of the total Fund, 56% is to go to fighting HIV/AIDS while 13% has been allocated to fighting TB and 31% to malaria.[20] African Heads of State had earlier committed themselves at Abuja, Nigeria to initiate appropriate action to ensure that by 2005: 1) at least 60% of those suffering from malaria have prompt access to and are able to use correctly, affordable and appropriate treatment within eight hours of the onset of symptoms; 2) at least 60% of those at risk of malaria, particularly pregnant women and children under five

[13] Op.cit., note 11. The Committee on Economic, Social & Cultural Rights (CESCR) has defined poverty as a 'human condition characterized by sustained or chronic deprivation of the resources, capabilities, choices, security and power necessary for the enjoyment of an adequate standard of living and other civil, cultural, economic, political and social rights' (WHO, 2005).

[14] Farmer, 2001, at 345.

[15] Id. See also 'How malaria impoverishes Uganda' *The Daily Monitor* 3 June 2008, at 3.

[16] The MGDs are available at http://www.un.org/millenniumgoals/goals, accessed April 7, 2008. Goal 1 requires states to reduce by half the proportion of people living on less than a dollar a day and those suffering from hunger. Goal 5 enjoins states to combat HIV/AIDS, Tuberculosis and Malaria.

[17] Paul Hunt 'Poverty, Malaria and the right to health: Explaining the Connections', available at http://www.moblizing4malaria.org/data/files/10_dec_2007_malaria_paper_with_footnotes_18_dec_07, accessed 3 July 2008. On the problem of other neglected diseases, see 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt on his mission to Uganda', available at http://www2.essex.ac.uk/human_rights_centre/rth/docs/Ugnada.pdf, accessed 12 September 2008.

[18] World Bank, op.cit., note 1. It is disturbing to note that the strategy is not about eradication of malaria as such but 'rolling it back'!

[19] 'President's Malaria Initiative: Malaria in Uganda', available at http://www.fightingmalaria.gov/countires/uganda.html, accessed April 16, 2008.

[20] Id.

years of age, benefit from the most suitable combination of personal and community protective measures such as insecticide treated nets (ITN) and other materials to prevent infection and suffering; and 3) at least 60% of all pregnant women who are at risk of malaria, especially those in their first pregnancies, have access to chemoprophylaxis or presumptive intermittent treatment.[21]

Through the Health Sector Strategic Plan[22] and the Uganda Malaria Control Strategic Plan (UMCSP),[23] the Ministry of Health has also prioritized areas of intervention including: 1) improving case management of clinical malaria through highly effective artemisinin-based combination therapy delivered at health facilities as well as at the community/household level through home based management of fever; and 2) malaria prevention using a combination of ITN and indoor residual spraying.[24]

Against the above background, this paper examines the policies, programmes and strategies related to the fight against malaria with a view of assessing the extent to which they enhance or inhibit protection of the right to health generally and the right of access to malaria treatment in particular. The paper also explores the modalities through which the relevant actors, including non-state actors, can be held accountable for violations of the right of access to malaria treatment in Uganda. Consequently, the paper is divided into five sections. The first section is this introduction. The second section outlines the nature, scope and content of the right of access to malaria treatment. The third section critically examines the legal and policy frameworks in light of the human rights standards laid out in the preceding section. The fourth section explores juridical and other strategies that may be employed to enhance promotion and protection of the right of access to malaria treatment. The final section presents conclusions and recommendations.

[21] The Abuja Declaration on Roll Back Malaria in Africa, African Summit on Roll Back Malaria, April 25, 2000, Abuja Nigeria.
[22] Op.cit., note 12.
[23] Ministry of Health, 2005b.
[24] Id.

II. THE RIGHT OF ACCESS TO MALARIA TREATMENT IN UGANDA: THE POLICY AND LEGAL FRAMEWORK

2.1 The international context

The human right to health, enshrined in international law and like other socio-economic rights, is now firmly entrenched at the international stage.[25] It is now widely accepted that socio-economic rights are as legally and normatively valid as civil and political rights. A key component of the right is access to medication and affordable health services. The Universal Declaration of Human Rights (UDHR) guarantees everyone the right to a standard of living adequate for health including medical care and necessary social services.[26] The International Covenant on Economic Social and Cultural Rights (ICESCR) recognizes 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.[27] In order to realize this right, states parties must take steps including those 'necessary for the prevention, treatment, and control of epidemic, occupational and other diseases'[28] and 'the creation of conditions which would assure to all medical attention in the event of sickness'.[29] In the same way, according to WHO, the highest attainable standard is 'one of the fundamental rights of all human beings without distinction as to race, colour and religion'.[30] The African Charter on Human and Peoples' Rights (ACHPR) provides for every individual to enjoy 'the best attainable state of physical and mental health'[31] and mandates states parties to take the 'necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick'.[32]

The Committee on Economic, Social and Cultural Rights (CESCR), which is responsible for implementing, monitoring and enforcing economic, social and cultural rights, has clarified the normative content and scope of the right to health.[33] The CESCR has stated that the states parties should not only progressively realize the right to health but also meet immediate obligations including minimum core ones.[34] States parties must ensure that health facilities goods and services are physically and economically accessible (affordable) and the people must access information about such goods and services. The CESCR obliges states to provide essential drugs as from time to time

[25] George J Annas 'The right to health and the nevirapine case in South Africa' *The New England Journal of Medicine* available at http://content.nejm.org/cgi/content/full/348/8/750, accessed 4 June 2008.
[26] Article 25 (1) UDHR.
[27] Article 12 (1) ICESCR.
[28] Article 12 (2) (c).
[29] Article 12 (2) (d).
[30] Constitution of WHO.
[31] Article 16 (1) ACHPR.
[32] Article 16 (2) ACHPR.
[33] CESCR, General Comment 14, 'The Right to the Highest Attainable Standard of Health', Twenty Second Session, 25 April-12 May 2000, Geneva, EC. 12/2000/4.
[34] See, General Comment No. 3 of 1990, UN. Doc.E/1991/23, Annex III, UN ESCOR, Supp. No.3. See also: *Limburg Principles* (1987) *HUM. RTS* 9. See also, General Comment 14, 'The Right to the Highest Attainable Standard of Health', Twenty Second Session, 25 April-12 May 2000, Geneva, EC. 12/2000/4.

defined by WHO's Action Programme on Essential Drugs.[35] In implementing these measures, the states parties are enjoined to pay particular attention to vulnerable or marginalized groups. Although the General Comments of the Committee do not have binding effect, they are considered authoritative guidance on clarifying the contents of rights and obligations enshrined in the Covenant.[36] The WHO has observed that the General Comments, 'constitute an important foundation for arguments that treat access to essential treatments, preventives and diagnostics as a right, and entail particular obligations on states'.[37]

According to the Committee, the right to health connotes a right to 'the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health'.[38] States must promote the right to health through ensuring access to affordable treatments of diseases. States must ensure that health facilities, goods and services are available, accessible, acceptable and of good quality.[39] Availability connotes the existence of functioning public health care facilities, and goods and services. Accessibility refers to a situation where there is equitable access and rational use of quality essential medicines.[40] The element of accessibility contains an essential element: affordability of the facilities, goods and services, including essential drugs.[41] States parties should ensure that the right to health is given due attention in international agreements and they must take steps to ensure that these agreements do not negatively impact on the realization of the right.[42] Violations of the right to health can result from the actions of states or other entities insufficiently regulated by the state.[43]

2.2 The Domestic Context

Uganda's legal framework does not specifically provide for the right to health. However, the 1995 Constitution contains some provisions which are relevant to the right under inquiry. The Constitution obliges the state to 'take all practical measures to ensure the provision of medical services to the population'[44] and to ensure that all Ugandans enjoy 'rights and opportunities and access to….health services….'[45] Although these provisions are in the National Objectives and Directive Principles of State Policy (NODPSP), there is emerging jurisprudence to show that NODPSP may be justiciable. A creative court can effectively apply NODPSP. For example, in the Indian case of

[35] Id.
[36] WHO 'Report of the Commission on Intellectual Property Rights, Innovation and Public Health' available at http://www.who.int/intellectualproperty/documents/thereport/ENPublicHealthReport.pdf, (accessed 6 June 2008).
[37] Id.
[38] Id.
[39] Paras. 12 (a)-(d), General Comment 14.
[40] Op.cit., note 10.
[41] Id.
[42] Para 39, General Comment 14.
[43] Paras 50-52, General Comment 14. See also, Chapman, 1996.
[44] NODPSP XX.
[45] NODSP XIV (b).

Keshavananda Bharati v. State of Kerala[46] the Supreme Court stated that although Article 37 of the Indian Constitution expressly provides that the Directive Principles of State Policy (DPSP) are not enforceable by any court, they should enjoy the same status as traditional fundamental rights. Some commentators have also pointed out that Directive Principles of State Policy (DPSPs), though not justiciable, are benchmarks for measuring the performance of the government.[47] Thus, a bold and creative judiciary may vest DPSPs with legal significance.[48]

The Ugandan Constitution guarantees the right to life,[49] which has implications for the right to health if interpreted widely. The state has a duty to take positive measures to protect and ensure the right to life through the prevention of death. For example, the Human Rights Committee has explained that the expression 'inherent right to life' should not be 'understood in a restrictive manner, and the protection of this right requires that states adopt positive measures' aimed at for example the reduction of infant mortality and improvement of life expectancy.[50] National courts elsewhere have held that a denial of the right to health may have serious ramifications for the right to life. In *Paschim Banga Khet Mazdoor Sanity and Others v State of West Bengal and Another*,[51] the claimant suffered serious head injuries as a result of an accident. He was turned away from government hospitals and obtained treatment from a private hospital. The Indian Supreme Court stated:

> *Article 21 imposes an obligation on the state to safeguard the right [to life] of every person. Preservation of human life is thus of paramount importance. The government hospitals run by the state and the medical officers employed therein are duty bound to extend medical assistance for preserving human life. Failure on the part of a government hospital to provide timely medical treatment results in violation of his right to life under article 21.*

In *Glenda Lopez v. Instituto Venezulano de Seguros Sociales*,[52] the Supreme Court of Venezuela held that the denial of access to certain medicines such as ARVs constituted a violation of the right to life.

Indeed, some judges in Uganda have also breathed life into the constitutional provision on the right to life. For example, in *Salvatori Abuki and Another v Attorney General*,[53] the petitioner challenged the exclusion order, which was made under section 7 of the Witchcraft Act,[54] as being inconsistent and in contravention of the Constitution. He argued that the order deprived him of his property and the right to reside and settle

[46] (1973) 4 SCC 225.
[47] See for example, Okere, 1983.
[48] Id.
[49] Art 22 (1) of the Constitution.
[50] UN Human Rights Committee General Comment 6, art 6 (right to life), 1982, HRI/Gen/1/Rev 2, 6-7, para 5.
[51] (1996) 4 SCC 37.
[52] Constitutional Chamber 1997.
[53] Constitutional Petition 2/1997(unreported).
[54] Chapter 124 Laws of Uganda.

in any part of Uganda. The Court held that the exclusion order was unconstitutional since it threatened the right to life through deprivation of shelter, food and essential sustenance.

The Constitution also provides for other rights not specifically mentioned as follows:

> *[t]he rights, duties, declarations and guarantees relating to the fundamental and other human rights and freedoms specifically mentioned in this Chapter shall not be regarded as excluding others not specifically mentioned.*[55]

As illustrated above, the right to health care is defined in international instruments to which Uganda is a party. It can thus be argued that the right is covered under those rights not specifically included in the Constitution. The Constitution obliges all organs and agencies of government and all persons to respect, uphold and promote human rights.[56] On the basis of this, it is submitted that the state must respect the right by adopting laws and policies that enhance protection of the right of access to malaria treatment in the context of the right to health. The state must also protect the population from effects of policies imposed upon states by private persons such as pharmaceutical companies.[57]

Uganda is party to international human rights instruments and therefore has obligations to respect, protect and fulfill the right to health generally and the right of access to malaria treatment in particular. These obligations are largely concerned with holding the government accountable to its commitments as spelt out in the Constitution and international human rights instruments. It is also important to note that human rights law recognizes resource constraints placed particularly on poor countries like Uganda. To this end, the major concern is with the steps, which the state has taken toward the progressive realization of the right to health to the 'maximum available extent of its resources'.[58] However, the 'minimum core' principle demands that regardless of resources, the state should 'ensure the satisfaction of, at the very least, minimum essential levels' of each of the rights in the ICESCR.[59]

It should be noted that in general, treaties such as the ICESCR do not create direct obligations for private persons. In international law, it is not clear whether a private person can be held responsible for violation of the right to access to health care. However, the 1995 Constitution imposes obligations on private persons to respect human rights. The Constitution provides that it is the duty of every citizen of Uganda to respect the rights and freedoms of others[60] and to protect vulnerable persons against

[55] Article 45 of the Constitution.
[56] Article 20(2) of the Constitution.
[57] There have been calls for making pharmaceutical companies accountable. See for example, Nwobike, 2006.
[58] Article 2(2) of ICESCR.
[59] Para 43 General Comment 14.
[60] Article 17 (1) (b).

any form of abuse, harassment or ill treatment.[61] The Constitution further provides as follows:

> *The rights and freedoms of the individual and groups enshrined in this chapter [Four] shall be respected, upheld and promoted by all organs and agencies of Government and by all persons (emphasis mine)*[62].

The word 'persons' includes natural and artificial persons.[63] It can thus be argued that this constitutional provision moves accountability beyond the traditional focus on the state as sole protector of human rights. Private persons—whether in the family, community, government or the market—can be held accountable for the violation of human rights, such as the right to health care. Consequently, private persons such as NGOs, private health facilities and health professionals can be held accountable if for example they refuse to provide emergency care to patients for want of affordability. Pharmaceutical companies can also be held accountable for violations of the right of access to malaria treatment. Violations perpetrated by these companies may include putting counterfeit drugs on the market and not being thorough with the negative side-effects of the drugs manufactured. Some companies have also failed to undertake measures that would make their drugs affordable. In fact, there have been calls for the establishment of human rights standards which private entities such as pharmaceutical companies should follow in the pursuit of their business. Paul Hunt, the Special Rapporteur on the right to health has in fact produced draft human rights guidelines for pharmaceutical companies in relation to access to medicines. The Special Rapporteur is of the view that such guidelines would assist those who wish to monitor the human rights performance of the pharmaceutical sector in relation to access to medicines. Hunt suggests that the pharmaceutical companies should integrate human rights, including the right to health within their strategies, policies, programmes, projects and activities that bear upon access to medicines.[64]

[61] Article 17 (1) (c).
[62] Article 20 (2).
[63] Interpretation Act, Cap 3 Laws of Uganda 2000.
[64] See generally, Paul Hunt, Draft Human Rights Guidelines for Pharmaceutical Companies in Relation to Access to Medicines, 19 September 2007, available at http://www2.essex.ac, accessed 4 July 2008.

III. THE LEGAL AND POLICY FRAMEWORK FOR MALARIA CONTROL IN UGANDA

3.1 The Legal Framework

In Uganda, there is no law that specifically deals with the right to health and its components like the right of access to malaria treatment. The available legislation is either outdated and outmoded or piecemeal and simply inadequate in ensuring protection of the right to health generally and the right of access to malaria treatment in particular. Most of the issues concerning the malaria fight are covered under policies, which are not legally binding.

The main legislation on the protection of public health is the Public Health Act.[65] Although some of the provisions of this Act may burden human rights, it contains certain aspects that may be used in the fight against malaria. This Act empowers the Minister [of health] , by statutory order, to declare any part of Uganda that appears to be threatened by any disease an infected area. The Minister may also make rules for the purposes of the destruction of mosquitoes.[66] Part XI is dedicated to the prevention and destruction of mosquitoes. This part imposes obligations on owners and occupiers of premises to clear bushes and to ensure that such places as yards, cesspits and wells do not become breeding places for mosquitoes.[67] Certain actions in contravention of these provisions may be treated as nuisances[68] and the culprit may be ordered to remove or abate the nuisance.[69]

One of the major weaknesses of the Act in general, and Part XI in particular, is that there is over reliance on criminal sanctions as an enforcement mechanism. It cannot be denied that criminal law is a powerful tool that may serve several societal goals and may express a collective social view that a particular behaviour is wrong. Criminal law may also be a means through which a social group obtains social validation of its views. However, the penalties are not punitive enough to achieve their intended purpose. It should also be noted that the enforcement of these provisions may also threaten some civil and political rights. The criminalization of the acts or omissions of owners or occupiers of premises may, for instance, threaten the right to privacy as guaranteed by the Constitution and international instruments to which Uganda is a party.[70] Although this right is not absolute, its limitation must be proportional to the end sought and be necessary in the circumstances of any given case[71] and must not be 'beyond what is acceptable and demonstrably justifiable in a free and democratic society'.[72] It should also be noted that the Act is generally obsolete having failed to keep pace with rapid

[65] Cap. 281, Laws of Uganda.
[66] Section 29 (j) of the Public Health Act.
[67] See sec 93-100 of the Act.
[68] Section 29 (j) and 57(h) and (i).
[69] Sections 58-61 of the Act.
[70] Article 27 of the Constitution. On invasion of the right to privacy for persons living with HIV/AIDS, see for example, Z Lazzarini & R Klitzman, 2002.
[71] See, Human Rights Committee, *Toonen v Australia*, Communication 488/1992, para. 8.4.
[72] Aricle 43 (2) (c) of the Constitution.

and extensive changes in science and technology in the areas of prevention, treatment and care.

The National Drug Policy and Authority Act[73] establishes the national drug policy and a National Drug Authority (NDA) to ensure the availability, at all times, of essential, efficacious and cost-effective drugs to the entire population of Uganda to provide satisfactory health care.[74] The Act requires a continuous review of the needs, knowledge and resources of essential drugs.[75] The NDA is charged with the implementation of the drug policy, particularly: 1) estimate drug needs to ensure that the needs are met as economically as possible; 2) control the importation, exportation and sale of pharmaceuticals; 3) promote and control local production of essential drugs; 4) control the quality of drugs; and 5) promote rational use of drugs through appropriate professional training.[76] The NDA and other regulatory and enforcement agencies have to prevent the importation or sale of substandard and fake anti-malaria drugs.

Another piece of legislation relevant to the right of access to malaria treatment is the National Medical Stores Act.[77] This Act establishes the National Medical Stores (NMS) charged with 'the efficient and economical procurement of medicines and of certain other medical supplies of good quality primarily to the public health services.'[78] This is in addition to securing safe and efficient storage, administration, and distribution of drugs.[79] The NMS has a very important role of ensuring that drugs, including those for malaria treatment, are availed to public health facilities including hospital and clinics. The NMS also has the duty to advise the NDA on the 'estimation of drug needs and the distribution and use of medicines in the public service'.[80] However, going by recent media reports, the NMS has not adequately performed its statutory functions.[81] It has been reported that the NMS distributes expired drugs and drugs that are very close to their use-by dates.[82]

It should be noted that unlike the Medical and Dental Practitioners Act[83] which establishes a Council to deal with malpractices by the relevant health professionals,[84] the National Medical Stores Act omits the establishment of such a body. Such a professional

[73] Cap. 206 Laws of Uganda.
[74] Section 2 (1) (a) of the Act.
[75] Section 2 (1) (b) of the Act.
[76] On the functions of the NDA see generally section 5 (a)-(k).
[77] Cap. 207, Laws of Uganda.
[78] Section 4 (a) of the Act.
[79] Section 4 (b) of the Act.
[80] Section 5 of the Act.
[81] A scandal recently hit the NMS whereby huge amounts of ARVs expired due to negligence. See, B. Simson & H. Nabayunga, 'Health probes ARV expiry', *The Daily Monitor*, Sept. 8, 2006, at 6 Shamelessly, the National Medical Stores is presently looking for Uganda shillings 800 million (about US $ 500, 000) to destroy ARVs and anti-malaria drugs.
[82] See, 'Arrest officials who issue expired drugs' *The Daily Monitor*, 16 July 2008 at 32.
[83] Cap. 272, Laws of Uganda.
[84] See sections 2 and 3 of the Act.

body could have been used to demand accountability from the Board of Directors of the corporation. The Ministry of Health is merely on the receiving end of drugs from NMS, whose officials may not be subjected to ethical accountability by their peers.

3.2 The Policy Framework

The CESCR has observed that the realization of the right to health and its components may be pursued through numerous complementary approaches such as the formulation of health policies or the implementation of health programmes.[85] These policies and programmes must give sufficient recognition to the right to health in the policy framework. According to the Committee, it is incumbent upon States parties to ensure that there is a detailed plan for realizing the right to health, including provision of health care.[86] In this regard, one of the core obligations of States parties identified by the Committee is:

> *To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as the right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.*[87]

The purpose of the indicators is to monitor the extent to which the state is complying with its obligations to realize the relevant components of the right to health. States are required to set appropriate benchmarks in relation to each indicator.[88] To this end, Uganda has developed a number of policies and programmes, with various indicators and benchmarks indicating how the state intends to tackle the malaria burden. Below, I consider some of the salient features of the policy framework.

3.2.1 The Poverty Eradication Action Plan (PEAP)

The PEAP is Uganda's national planning framework. Its main purpose is to provide an overarching framework to eradicate poverty. It provides a framework within which sectors such as Ministry of Health should develop detailed plans. The PEAP has five pillars. One of the pillars is human development, which concerns issues such as health and education. According to the PEAP, 'a healthy and well-educated population is both a necessary condition for development and one of the central objectives of development.'[89] It is also recognized that 'the status of health and education also affect the overall economic growth'.[90] The PEAP identifies malaria control as one of the

[85] Para 1 General Comment 14.
[86] Para 36.
[87] Para 43 (f).
[88] Para 57-58.
[89] Id., at 147.
[90] Id.

major priorities of the state to be tackled through *inter alia* home-based management of fever (HBMF) with particular focus on under-five children to ensure that they receive treatment within 24 hours of onset of symptoms. Another important intervention is the introduction of free primary health care, including malaria treatment. However, the PEAP's macro-economic framework has been sharply criticized as being a re-incarnation of the failed and much discredited Structural Adjustment Programmes (SAPs).[91] It is argued that by emphasizing market-driven policies such as privatization, the PEAP is incompatible with the protection of socio-economic rights of the poor such as access to malaria treatment.[92]

3.2.2 Health Sector Strategic Plan (HSSP)

The Health Policy and the HSSP I and II identify malaria as one of the leading causes of morbidity and mortality in Uganda. As one of the responses, these Strategic Plans envisage the employment of preventive and case management interventions to tackle malaria. These interventions include intermittent preventive treatment in pregnancy (IPT); ITNs; and the artemesinin-based combination treatment (ACT) as a first line treatment regimen. The Plans outline the indicators to measure progressive realization of the obligation to control malaria. The specific targets of the HSSP include: 1) increase the proportion of pregnant women who have completed IPT2 from 34 to 80%; 2) increase the proportion of households having at least one ITN from 15 to 70%; 3) increase the proportion of children under five getting correct treatment within 24 hours of onset of symptoms from 25 to 80%; 4) reduce the case fatality rate among malaria in-patients under five from 4 to 2%.

3.2.3 Uganda Malaria Control Strategic Plan (UMCSP)

The UMCSP's vision is that by 2010, malaria will no longer be the major cause of illness and death in Uganda and there will be universal access to malaria prevention as well as treatment.[93] The overall goal of this Plan is to control and prevent malaria morbidity and mortality so as to minimize related social effects and economic losses attributable to malaria in the country. The Plan aims at providing a package of effective and appropriate interventions to promote positive behaviour change and to prevent and treat malaria in a sustainable manner. The Plan's core interventions include universal access to ACT and high quality clinical and parasitological diagnosis as well as severe malaria management and emphasis on treatment and prevention in pregnancy including IPT. The Plan focuses on the most vulnerable groups such as young children and pregnant women in highly endemic areas, internally displaced persons (IDPs) and persons living with HIV/AIDS (PLHA). According to the Plan, treatment with ACTs will be free in the public sector including the HBMF programme.[94] Pregnant women are to be

[91] Barya, 2001. See also, Twinomugisha, 2008.
[92] Barya, Id.
[93] Uganda Malaria Control Strategic Plan 2005/06-2009/10.
[94] On HBMF see, Ndugwa-Sabiiti *et al.*, 2007.

targeted through antenatal (ANC) services.[95] The Plan further provides that while the ACT will be given free to the not-for profit private sectors, there may be a charge levied to the patient for other parts of the treatment package. Other parts of the treatment may include laboratory tests and admission fees. The Plan promises to support NDA in terms of its capacity to monitor the quality of anti-malarial medicines.

The specific targets to be achieved by the Plan by 2010 include: 1) increase the proportion of under-five children receiving correct treatment within 24 hours of onset of symptoms from 55% to 85%; 2) increase the proportion of pregnant women attending ANC services who have received IPT2 from 33% to 85%; 3) reduce case fatality rate among malaria in-patients from 3% to 2%.

3.3 Appraisal of the Policy Framework

3.3.1 Challenges to Implementation: An Overview

In the Ministerial Policy Statement recently presented to Parliament, the Minister of Health, Hon. Dr. Steven Malinga, noted that malaria case management had improved with the change in the malaria treatment policy and the advent of ACTs on the scene.[96] However, the minister outlined some of the major challenges to the attainment of the set targets, including: 1) inadequate effective monitoring and evaluation systems able to document the impact of the investment in malaria control strategies; 2) lack of universal access to malaria control strategies; 3) increasing resistance to the malaria parasite (plasmodium) to affordable anti-malarial drugs, necessitating use of expensive alternatives; and 4) reduced funding for malaria.[97] Furthermore, the UMCSP also outlines key assumptions that must be met if the Plan's targets are to be attained and they include political will, additional funding for malaria control, availability of infrastructure and the needed supplies and products.[98]

The policy framework acknowledges that the limited number of drugs, limited health service infrastructure, limited health staff and a thriving black market restrict access to malaria treatment. Other barriers to treatment include low education and awareness of treatment, transport costs to reach the nearest health care provider and the cost of the required laboratory tests. The Presidential Malaria Initiative notes that 'diagnostic capacity in Uganda remains weak due to inadequate training for laboratory technicians and a shortage of equipment, supplies and human resources for laboratory services'.[99] Most malaria diagnoses in health facilities in Uganda are based on symptoms and not microscopy. Yet, without laboratory diagnostic capacity, it is very likely that a patient that presents with a fever but without malaria may not be treated with other supportive health measures. There are also reports of shortages and stock outs of ACTs and other

[95] On malaria in pregnant women, see Ndyomugyenyi *et al.*, 2007.
[96] Ministry of Health 'Ministerial Policy Statement 2007/2008 at 53.
[97] Id., at 56.
[98] Id., at 37.
[99] See, 'Presidential Malaria Initiative Uganda, Malaria Operational Plan (MOP) 2008' available at http://www.fightingmalaria.gov/countries/Uganda_mop-fy08.pdf, accessed 7 July 2008.

drugs in public hospitals. Some of the ACTs intended for public facilities end in private facilities. In light of these challenges, the question is: what is the potential of the policy framework to protect the right of access to malaria treatment?

A significant and indeed perennial challenge is inadequate funding for the health sector. The proportion of health spending within the government budget is around 10% (about US$ 8.30 per capita), which is only a small part of the estimated US $ 28 per capita health expenditure. The amount required to adequately fund the implementation of the Uganda Minimal Health Care Package (MHCP) is estimated at US $ 30-40 per capita, necessitating an increase in the health budget to at least 15%. Funds available for essential medicines, vaccines and supplies have increased from US$ 0.80 to 1.50 per person per year, but still far short of the US $ 3.50 needed to successfully implement the MHCP. The Minister of Health has decried the 'serious un-funded and under-funded priorities/activities for FY 2007/08'.[100] The key under-funded areas include medicines and health supplies by Ushs 77.8 billion.[101] Without disaggregating this data, it may even be difficult to know what is actually allocated to malaria treatment. A key informant expressed worry that HIV/AIDS has marginalized other critical areas in terms of both government and donor funding. He is of the view that compared to malaria and other epidemics that claim more lives; more funding is directed to HIV/AIDS prevention and treatment strategies.

It should be noted that over 50% of the malaria control budget is externally funded. While 'donor' support can help fill gaps in government funding, it is neither sustainable nor desirable as the major source of funding for social services such as malaria treatment.[102] The state should not abdicate its cardinal responsibility of protecting the right to health: it must invest more of its own money into the health sector to ensure that preventable and treatable diseases such as malaria do not continue to take the life of many people as it does every year. Increased and sustained funding is necessary to extend the current levels of ACT coverage.[103] As indicated earlier, in spite of resource constraints, the state has the burden of proving that it has used all the resources at its disposal in order to satisfy, as a matter of priority, the obligations to respect, protect, promote and fulfill the right to health. Other than this, however, the state cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations such as access to malaria treatment, which are non-derogable.[104] The state has an obligation to mobilize financial resources and channel the same to the realization of the right in question.

[100] Id.
[101] Ministry of Health, n 101.
[102] For a critique of donor funding in the health sector, see for example, Melina Platas 'How Donor Aid is Killing Uganda's Health Sector' *The Independent,* Issue 021, August 8-15, 2008 at 14-15.
[103] See Bosman & Kameni, 2007.
[104] Para. 47.

3.3.2 Positive Discrimination in Malaria Treatment?

On a positive note, the policy framework lays down the targets, indicators and benchmarks for malaria control as required by human rights law. The policy framework spells out national responses to malaria care, treatment and support. It also prioritizes the provision of anti-malaria treatment. Although the policy framework aims at providing universal access to ACT, it focuses on pregnant women, under-five children and PLHA as a priority in the provision of malaria related goods and services. This may be taken as some kind of positive discrimination, which is recognized by the Constitution.[105] However, the policy framework ignores other individuals and groups who are vulnerable and marginalized, for example, non-pregnant poor women, orphans and other children from poor families, and even poor men. The mosquito does not discriminate: every malaria patient requires treatment. The obligation to fulfill the right to health requires the state to provide diagnosis and treatment of illness, including malaria, to all those individuals or groups, who are unable for reasons beyond their control to realize the right by the means at their disposal.[106]

3.3.3 A Gender Neutral Policy Framework

The CECR enjoins states to integrate a gender perspective in the policy framework in order to promote better health for both men and women.[107] A gender perspective 'recognizes that biological and socio-cultural factors play a significant role in influencing the health of men and women'.[108] According to Akin Aina, gender relations refer to, social relations of domination and subordination found between men and women and structured into the institutions and workings of society ranging from the most basic level of the household and the family, to the far more extensive domain of the state and political structures, the market, economic institutions and agents.[109]

Thus, the concept of gender relations refers to the distinctive characteristics of women and men that are culturally, socially and economically determined. However, this concept has not received enough attention in the policy framework on malaria control and other health interventions. Yet, women bear a disproportionate part of economic recession and impoverishment since they assume the main responsibility for family survival strategies by working long hours inside and outside the home, caring for the sick and raising children. There is evidence that because of their different positioning in society, poverty impacts on women and men differently. Because of their multiple gender roles, women work harder in mainly taking up domestic chores that do not necessarily result in individual incomes to provide for their needs including health care services.

[105] Article 34 of the Constitution.
[106] Para. 37, General Comment 14.
[107] Para 20.
[108] Id.
[109] Aina, 2007.

It is not enough for the policy framework to focus on pregnant women in the provision of malaria treatment. Gender relations must become an integral part of all poverty related issues such as access to malaria treatment. Policy makers must realize that most poor women, especially in rural areas may, because of their multiple gender roles hardly get time to effectively access malaria treatment. It is trite that poor women have limited access to and control of physical and financial resources. Although the CESCR stresses information accessibility,[110] the poor, especially women, have little or no meaningful access to information on malaria prevention and control.[111] Thus, it is necessary for the policy framework to indicate how the state intends to tackle inequitable gender relations that inhibit women from accessing malaria treatment. Adjusting entrenched and deeply embedded norms may not be easy. However, the concept of progressive realization demands that the state devises a plan with measurable indicators and benchmarks to tackle such norms. The CESCR recommends that the 'disaggregation of health and socio-economic data according to sex is essential for identifying and remedying inequalities in health'.[112] The policy framework must therefore not be gender neutral: it must disclose how many men and women are targeted within a given time frame.

3.3.4 Nutrition Neglected

It should be noted that the importance of good nutrition in strengthening immune systems is well established. Improving the nutritional status of pregnant women is essential to reduce maternal deaths.[113] A child deficient in Vitamin A faces a greater risk of dying from common ailments such as malaria, measles or diarrhea.[114] Most medications, including malaria treatment, require adequate food and nutrition. However, the policy framework does not include strategies for ensuring that the ACT regimen is accompanied by the necessary nutrients. This is not a moral obligation: the state is under obligation to protect the right to adequate food for vulnerable persons such as pregnant women and children under malaria treatment.[115]

3.3.5 Role of Traditional Medicine Ignored

The policy framework recognizes the fact that the performance of the health sector is constrained by limited health staff. In Uganda, the doctor-patient ratio is at 1:18000.[116] Most health personnel may prefer employment in the private sector where they are better remunerated or may seek greener pastures abroad. There is evidence to show that many people, especially in the rural areas utilize the services of traditional healers because they are more accessible. Traditional birth attendants attend to many pregnant women and children.[117] In spite of this, the policy framework does not contain any strategies to

[110] Para 12 (b), General Comment 14. Accessibility includes the right to seek, receive and impart information and ideas concerning health issues.

[111] See for example, Fred Simiyu ' Mayuge in danger as mosquito, tsetse fly traps become fish nets' *The Saturday Monitor*, 2 August 2008, at 11.

[112] Para. 20, General Comment 14.

[113] See, 'Nutrition' available at http://www.unicef.org/nutrition/index_action.html, accessed 6 August 2008.

[114] Id.

[115] On obligations of the State in respect of protection of the right to adequate food, see Twinomugisha, 2005b.

involve TBAs and other traditional healers in the management of uncomplicated malaria. The policy framework does not also indicate how alternative/traditional medicine for the treatment of malaria may be preserved.

3.3.6 Lack of Benchmarks for Participation

The cornerstone of any meaningful health policy must be Primary Health Care (PHC), which calls for the provision of essential health care to individuals and families through their full participation. According to the PHC concept, the people have the right and duty to participate individually and collectively in the planning and implementation of their health care.[118] The CESCR also underlines the right of individuals and groups to participate in the decision-making processes, including policy formulation and implementation.[119] The people must be involved in the 'setting of priorities, making decisions, planning, implementing and evaluating strategies to achieve better health'.[120] Apart from the muted reference to decentralization of health care services, the policy framework is silent about the question of participation. There is a need to establish benchmarks and mechanisms through which people at the grassroots can participate in the design, implementation, monitoring and evaluation of the policies and programmes intended for their benefit.

3.3.7 The Patent Regime: An Obstacle to Access to Treatment

Finally, the policy framework does not take into account the impact of the patent regime on the realization of the right to health generally and the right of access to essential treatment in particular. Access to malaria treatment is partly compromised by the high prices charged by pharmaceutical corporations, which are facilitated by the protection afforded to pharmaceutical patents by the Trade Related Aspects of Intellectual Property (TRIPS) Agreement.[121] As Sisule F Musungu has observed:

> *The grant of a patent over processes for the manufacture of medicines or with respect to medicines themselves as products has the effect of giving the patent holder a monopoly over the use of the process and or the manufacture and sale of the medicines…. For medicines, the high prices of new medicines resulting from the mandatory requirements for patent protection under TRIPS in developing countries have seriously compromised the ability of communities, governments and other players in the health sector effectively to manage infectious and other diseases.*[122]

The TRIPS Agreement prescribes minimum standards that relate to the protection of intellectual property rights (IPRs), including patents, trademarks, copyright and industrial

[116] Id.
[117] Twinomugisha,2005a.
[118] For details of the PHC concept, see Declaration of Alma-Ata 'Health for All' Series No. 1, Geneva: World Health Organization, 12 September 1978.
[119] Para 54 General Comment 14.
[120] Id.
[121] Joseph, 2003.
[122] Musungu, 2005, at 306.

designs. The minimum standards of the TRIPS Agreement are binding on all the World Trade Organization (WTO) members, including Uganda. Members are obliged to domesticate the TRIPS standards, failure of which may attract trade sanctions. The TRIPS Agreement protects 'process patents', which are concerned with the protection of methods of manufacturing, and 'product patents', which relate to the protection of pharmaceutical products. Patent protection is justified by developed countries and pharmaceutical companies on grounds that they act as incentives for drug innovation, research and technological development.[123] They argue that patents enhance access to medicines through the development of new drugs. However, developing countries and civil society organizations have argued that patents increase prices and limit access to medicines by placing them beyond the reach of poor people in developing and least developed countries (LDCs) such as Uganda.[124]

In order to balance the need to protect public health and IPRs, the TRIPS Agreement permits the utilization of a number of flexibilities such as compulsory licensing, government-use orders[125] and parallel importation[126] as policy tools to enhance access to medicines. Due to 'financial and administrative constraints, and their need for flexibility to create a viable technological base',[127] LDCs were allowed ten years to implement the TRIPS Agreement, except the national treatment and most favoured nation obligations.[128] Thus, LDCs were in general supposed to comply with TRIPS obligations as of 1 January 2006.[129] However, LDCs have been exempted through a WTO waiver from obligations to grant exclusive marketing rights for pharmaceutical products until 1 January 2016.[130] The TRIPS Council decided to implement paragraph 7 of the Doha Declaration on the TRIPS Agreement and Public Health whereby LDCs

[123] Id.

[124] Id.

[125] Compulsory licensing promotes access to generic medicines through local production by allowing a governmental agency or a private company to manufacture pharmaceutical products in the public interest without the patent holders consent. A government use order is permission granted to enable a government or third parties to make use of a patent without the consent of the patent holder for non-commercial purposes and the benefit of the public. Unlike a compulsory license, a government use order is restricted to public non-commercial use. Members are permitted to issue compulsory licenses for any legitimate reason such as ensuring access to medicines. Members have the freedom to determine the grounds upon which the compulsory license is given. They can manufacture generic versions of patented medicines without the consent of the patent owner in the circumstances pointed out above. Where patented drugs are too costly, the state can issue a compulsory license to an agency or company to manufacture or import a generic version of that patented drug which can be made more available to patients at a cheaper cost. Thus compulsory licensing is a tool for reducing prices and increasing availability of drugs to the population.

[126] Parallel importation occurs when prices of medicines are compared, and medicines are bought cheaply on the world market, and imported to a country in need. The imported products will have been produced pursuant to a compulsory license or government use order issued in the exporting country. Parallel importation enables a country to obtain drugs that are cheaper and yet of good quality.

[127] Article 66 (1) of the TRIPS Agreement.

[128] Id.

[129] Id.

[130] WTO 'Extension of the transition period under article 66.1 of the TRIPS Agreement for least developed country members for certain obligations with respect to pharmaceutical products' Decision of the Council of TRIPS of June 2002, IP/C/25.

shall be free to disregard the TRIPS obligations on patents and undisclosed information with respect to pharmaceutical products until 1 January 2016.[131] Though as a LDC Uganda is permitted to request for an extension of this period, it has not done so.

It should be noted that the TRIPS Agreement offers WTO members opportunities to develop appropriate national strategies to ensure regular access to medicines to meet the health needs of the people.[132] At the Doha Round of WTO negotiations in November 2001, developing countries, LDCs and civil society advocated for a more detailed clarification of the TRIPS flexibilities, such as compulsory licensing and parallel importation.[133] The Doha Declaration on the TRIPS Agreement and Public Health[134] reaffirmed the flexibilities in the TRIPS Agreement and stated as follows:

> *We agree that the TRIPS Agreement does not and should not prevent Members from taking measures to protect public health. Accordingly, while reiterating our commitment to the TRIPS Agreement, we affirm that the Agreement can and should be interpreted in a manner supportive of WTO Members' right to protect public health and, in particular, to promote access to medicines for all.*[135]

The language used in the above text acknowledges the unmitigated right of countries to take measures to protect public health. Thus, where patent rules are an obstacle to access to medicines, countries are permitted to override the patent regime. Although the Doha Declaration recognizes the importance of intellectual property protection for the development of new medicines, it also notes the 'concerns about the effect on prices'.[136] The Doha Declaration also affirms 'the right of WTO Members to use, to the full the provisions in the TRIPS Agreement, which provide flexibility for this purpose'.[137] The flexibilities include 'the right to grant compulsory licenses and the freedom to determine the grounds upon which such licenses are granted'.[138]

In the Doha Declaration, Members recognized the issue of limited pharmaceutical production capacities in developing and LDCs and thus the fact that they could 'face difficulties in making effective use of compulsory licensing under the TRIPS

[131] Id.

[132] A number of resolutions of the World Health Organization (WHO) have also emphasized the importance of flexibilities in the TRIPS Agreement. For example, resolution WHA 57.14 enjoins Member States '…to encourage that bilateral trade agreements take into account the flexibilities contained in the TRIPS Agreement and recognized by the Doha ministerial Declaration on the TRIPS Agreement and Public Health'. See, WHO Resolution WHA 57.14 'Scaling up treatment and care within a coordinated and comprehensive response to HIV/AIDS' in *Fifty-seventh World Health Assembly* (Geneva: World Health Organization, 2004).

[133] For details of the events leading to the Doha Declaration, see Gathii, 2002.

[134] WTO Ministerial Conference, Declaration on the TRIPS Agreement and Public Health (adopted 14 November 2001) Fourth Session, Doha, WTO/Min (01)/DEC/2 (20 November 2001) (hereinafter 'the Doha Declaration).

[135] Para. 4 of the Doha Declaration.

[136] Para. 3 of the Doha Declaration.

[137] Id. The state and civil society are currently debating the draft Industrial Property Bill which intends to incorporate most of the TRIPS flexibilities and repeal the Patents Act, cap 216.

[138] Para. 5 (b) of the Doha Declaration.

Agreement'.[139] What the members specifically had in mind in this respect was the requirement that production should be 'predominantly for the supply of the domestic market'.[140] This effectively limited the ability of countries that cannot manufacture pharmaceutical products from importing cheaper generics from countries where pharmaceuticals are patented. In response to this problem, the WTO on August 30th 2003, gave an interim waiver to an exporting country from having to comply with article 31(f) restriction, if it is exporting to countries with no or insufficient manufacturing capacity.[141] The August 30 decision allows any member country to export pharmaceutical products made under compulsory licenses provided that the country of export and the country of import have issued such licenses and notified the TRIPS Council of such importation or exportation. The decision covers patented products or products made using patented processes in the pharmaceutical sector, including active ingredients and diagnostic kits.[142]

[139] Para. 6 of the Doha Declaration.
[140] Article 31 (f) of the TRIPS Agreement.
[141] WTO General Council Decision of August 30, 2003 'Implementation of paragraph 6 of the Doha Declaration on the TRIPS Agreement and public health', WT/L/540 and Corr.1, September1, 2003, para 6.
[142] Khor, 2004.

IV. STRATEGIES FOR THE ENHANCED PROTECTION OF THE RIGHT

The protection of the right to health—including the right of access to malaria treatment—can be achieved through legislative, judicial, executive and other related strategies. In this section, I discuss major strategies that may be utilized in order to enhance protection of the right.

4.1 Policy Strategies

4.1.1 Pursuing a Rights Based Approach (RBA)

Policy makers and implementers should be guided by a RBA in the execution of their obligations. The RBA requires that the policies and institutions for malaria eradication be based explicitly on the norms and values set out in human rights law. The RBA requires that poverty issues such as access to malaria treatment be treated as human rights issues because of their importance to the life of individuals and groups and not as commodities to be determined by market forces.[143] This approach means that malaria control or eradication is not simply a moral obligation but also a legal obligation on part of the state and its institutions. Thus, approaching an issue of poverty such as access to malaria treatment from the prism of human rights is to lift it from the status of simply a social programme or aspiration to an entitlement, giving rise to legal obligations.

The RBA attempts to expose the discriminatory and exclusionary behaviours responsible for violating human rights. The approach is people centred, participatory, equitable, non discriminatory and empowering.[144] It sets the achievement of human rights as an objective of development. All human rights must be respected in the development, planning and implementation of health policies. The RBA 'integrates the norms, standards and principles of the international human rights framework into the plans, policies and processes of development'.[145] In any case, as Palmer has noted, 'the most important question facing modern medicine involves human rights'.[146] The RBA requires that the policy framework should, as a priority, address the interests and concerns of the poorest and most vulnerable. The RBA gives effect to the conceptualization of human rights 'tools that crystallize the moral imagination and provide power in the political struggles'.[147]

4.1.2 Increased funding for health

The state should provide adequate resources to enable timely procurement of generic malaria drugs so that their supply is not compromised. Parallel importation of generic pharmaceuticals may lower the prices of drugs. For example, in Kenya, parallel

[143] Tindifa, 2007; Hausermann, 1998.
[144] Hausermann, *op cit*, n 26.
[145] Frankovits, in Frankovits 2002.
[146] Id.
[147] Uvin, 2004, at176.

importation of generics by the non-profit sector resulted in a fall in prices by between 40% and 65%.[148] The state must increase funding to the health sector from the current 8% to at least 15% as recommended at Abuja.[149] Uganda is permitted by the ICESCR to request for appropriate and specific international assistance for realization of the rights under the Covenant, including the right to health.[150] Technical assistance is necessary since implementing and enforcing all the objectives of the policy framework may overstretch the available resources and administrative skills. Uganda should continue collaborating with organizations such as WHO and other partners to ensure that malaria drugs are made available and accessible to those who need them. The World Health Assembly has already enjoined WHO *inter alia* 'to pursue all diplomatic and political opportunities aimed at overcoming barriers to access to essential medicines, collaborating with Member States in order to make these medicines accessible and affordable to the people who need them'.[151]

4.1.3 Tackling corruption

Although the policy is silent, there is corruption in the health sector.[152] Funds may be secured for the importation of malaria drugs but the same may not reach the poor and vulnerable. Availability does not necessarily mean access. Recently, funds from the Global Fund malaria, HIV/AIDS and TB were misappropriated.[153] Medicines destined for public health facilities end up in private pharmacies and clinics. Some of the drugs expire in stores. There is need to intensify the fight against corruption. One of the ways of tackling corruption in the health sector is through labeling of government procured drugs to ensure that they do not end up in private clinics. As WHO has observed, 'people are the most important part of any health system. The health sector is labour intensive and the performance of health systems depends on the availability of qualified and motivated workers'.[154] Thus, to alleviate corruption and generally curtail brain drain in the health sector, health workers' remuneration and other working conditions must be improved.

4.1.4 Increasing Awareness

There is a need for raising awareness about the human rights implications of the policies with a bearing on the right to health among legislators, judges, human rights

[148] R L Lettington & P Munyi 'Willingness and ability to use TRIPS flexibilities: Kenya case study', available at http://www.dfid.gov/uk/pubs/files/dfidkenyareport.pdf, (accessed on 9 June 2008).

[149] Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases (2001) OAU/SPS/ABU/326.

[150] Articles 2 (1) and 22 of the ICESCR.

[151] Id.

[152] Twinomugisha, 2007b.

[153] The scandal led to the institution of a commission of inquiry, which implicated key government functionaries including members of parliament, security personnel and ministers. Following donor threats to withhold any further aid, the implicated ministers of health are being prosecuted.

[154] WHO at 103.

commissioners, pharmaceutical companies and civil society. These groups need to be knowledgeable about strategies for malaria control generally and malaria treatment in particular so that they are equipped with skills to effectively monitor and demand accountability from the government. The knowledge and skills can be imparted in workshops, seminars, university curricula, and the media. A related issue is access to information. There is need to ensure that reliable information about malaria treatment is accessible to health professionals and patients so that they can take well-informed decisions and use medicines safely.

4.1.5 State Reporting

One of the principal mechanisms by which treaty bodies monitor the extent of compliance by states parties with their obligations under human rights treaties is through a mechanism of state reporting. Under the ICESCR, the state has an obligation to periodically report on the progress it has made realizing the right to health and its various components such as access to malaria treatment, and any difficulties encountered in the implementation of its obligations.[155] Unfortunately, Uganda has not complied with its reporting obligations under the ICESCR. It should be noted that the struggle by civil society to hold the state accountable at the international level might be constrained given that in the absence of state reports, no shadow reports may be successfully filed with the CESCR to challenge state inaction.[156] However, the state may be challenged through litigation to justify why it is not meeting its reporting obligations.

4.1.6 Utilizing TRIPS flexibilities?

It should be noted that Uganda's policy framework does not show the extent to which TRIPS flexibilities can be employed to promote access to malaria treatment. The question therefore is: to what extent can Uganda effectively utilize such flexibilities in order to enhance availability and access to essential medicines generally and malaria dugs and related supplies in particular? Uganda has insufficient technical expertise and infrastructural capacities effectively to implement most of the flexibilities. As a matter of fact, the country has a low manufacturing capacity with only six active pharmaceutical manufacturing companies.[157] Recently, Quality Chemicals Limited, a privately owned company, commenced local production of generic antiretrovirals (ARVs) and also intends to produce anti-malaria drugs.[158] Uganda also faces pressure from powerful countries and their pharmaceutical companies either not to implement the TRIPS flexibilities or to succumb to TRIPS plus pressure. Thus, it may be necessary for Uganda to adopt a regional approach to the use of flexibilities. Uganda can take

[155] On state reporting see, F L Seidensticker 'Examination of State Reporting by Human Rights Treaty Bodies: An Example of Follow-up at the National Level by National Human Rights Institutions,' German Institute of Human Rights Working Paper (2005).

[156] Id.

[157] Ministry of Health 'The National Drug Authority' available at http://www.health.go.ug/National_drug.htm, (accessed 8 June 2008).

[158] Id.

advantage of the East African Community (EAC), which comprises of Uganda, Kenya, Tanzania, Rwanda and Burundi. The EAC covers a surface area of 2,000,000 square kilometers with a population of approximately 100 million people who largely share a common history, culture and infrastructure.[159] Like most other developing and LDCs, all countries of the EAC have felt and experienced the worst consequences of TRIPS and its impact on access to medicines. Of all these countries, only Kenya is classified as a developing country; the rest are LDCs. Thus, EAC countries could cooperate as a block. There can also be exchange of relevant information with other regional blocks such as South African Development Community (SADC).

Regional economic blocks that have LDCs forming at least half of their membership are eligible to be treated as a 'domestic market' regarding the supply of generic medicines under compulsory licensing.[160] For example, Kenya as a developing country can export a pharmaceutical product produced or imported under a compulsory license to other EAC countries that share the health problem in question. In Kenya, following pressure from government and civil society organizations, patent holding companies have granted licenses to local manufacturers for the production of ARVs. Musungu *et al*[161] have argued that a regional approach to the use of flexibilities will enable similarly situated countries to address their constraints jointly by drawing on each other's expertise and experience by pooling and sharing resources and information. Baker also advocates for regional co-operation in the area of production of generic medicines, drug registration, and generally creating demand for access to medicines and for medicines procurement.[162]

A regional approach will enhance efforts by the countries involved to pursue common negotiating positions at the WTO and promote South-South cooperation on health and development. A common regional understanding and approach to TRIPS obligations will facilitate cooperation among intellectual property offices and between governments at large. The EAC countries must resist 'TRIPS-plus' provisions in any bilateral, regional and economic agreements entered into.[163] Recent Free Trade Agreements (FTAs) between developing and developed countries, especially FTAs involving the US, may undermine the use of TRIPS flexibilities for public health purposes.[164] Most FTAs limit the application of compulsory licenses and parallel importation and aim at ensuring adequate and effective protection of IPRs in conformity with the highest international standards. For example, the US-Morocco FTA prohibits the use of parallel importation

[159] Id.
[160] WTO General Council Decision, para 6.
[161] Musungu *et al*, 2004.
[162] Baker op. cit. , note 140, at 47-51
[163] On how pressure to implement TRIPS-plus provisions has been applied to countries such as Brazil, Ecuador, India, Thailand, Pakistan and South Africa, see A Chapman 'Approaching intellectual property as a human right: Obligations related to article 15 (c)' E/C.12/2000/12, para 71.
[164] Id.

by permitting the patent owner to prevent such importation through the use of contract and other measures.[165]

4.2 Juridical Strategies

4.2.1 Legislative Reform

Socio-economic rights should be directly incorporated in the Bill of Rights of the Constitution. There is an urgent need to explicitly recognize the right to health care in the Constitution. However, it is not enough to recognize the right in the Constitution. Matters concerning health should not be left to the policy framework, which does not create legally binding obligations. There is a need for a framework legislation that reiterates the state's obligations to respect, protect, promote and fulfill the right to health. As already stated, the advantage of framework legislation is that it lays down major standards in the area of prevention and treatment and leaves the details to sectoral or subsidiary legislation. The CESCR has outlined some of the essential features of a framework law as follows:

> *States should consider adopting a framework law to operationalize their right to health national strategy. The framework law should establish national mechanisms for monitoring the implementation of national health strategies and plans of action. It should include provisions on the targets to be achieved and the time-frame for their achievement; the means by which the right to health benchmarks could be achieved; the intended collaboration with civil society, including health experts, the private sector and international organizations; institutional responsibility for the implementation of the right to health national strategy and plan of action; and possible recourse procedures.*[166]

The framework legislation should domesticate all the international and regional human rights instruments that recognize the right to health, which Uganda has ratified. As the CESCR has observed, the incorporation of these instruments in the domestic legal order can significantly enhance the scope and effectiveness of judicial or other appropriate remedies.

4.2.2 Judicial Strategies

The judiciary can play a significant role in the struggle to realize the right to health generally and the right of access to malaria treatment in particular. Judicial strategies are important in a number of respects. Courts can clarify on the nature, scope and content of human rights, thereby enriching the jurisprudence in the area. This is particularly so regarding socio-economic rights such as the right to health which some commentators

[165] Id.

[166] CESCR, General Comment No. 14 *The right to the highest attainable standard of health*, 11/08/2000. E/C.12/2004/4, at para 56.

have argued that they are costly, aspirational and vague and therefore non-justiciable.[167] It has been submitted that judges are not particularly well equipped to deal with issues involving economic and social policies, which have budgetary implications.[168] However, both civil and political and socio-economic rights involve a specific course of action. Take, for example, the right to vote and that to a fair hearing, which involve the funding of elections, financial support to the judiciary, the construction of courts, and prisons. Alston and Quinn have correctly argued that:

> *The reality is that full realization of civil and political rights is heavily dependent on availability of resources and the development of the necessary societal structures. The suggestion that realization of civil and political rights requires only abstention on the part of the state and can be achieved without significant expenditures is partly at odds with reality.*[169]

It is true that certain socio-economic rights call for more extensive state action than civil and political rights. However, the main challenge may not be that socio-economic rights have budgetary implications, but what is at issue is the prioritization of expenditure. For example, what is the cost to the state of millions of people dying because of a lack of access to anti-malaria drugs? As indicated earlier, the socio-economic burden of malaria in terms of lost life and productivity is enormous.[170] Busia and Mbaye have noted that the failure of African countries to address the socio-economic welfare of their people may be due to 'misallocation of resources, bad economic policies, fraudulent aggrandizement and a debilitating lack of accountability'.[171]

By framing political and moral demands in the language of legal rights and constitutional obligations, the litigation process assists in placing issues on the agenda, both before the judge and the court of public opinion. Most of access problems revolve on lack of political will. Litigation can therefore be used in challenging inappropriate state action, and addressing state inaction. Litigation can also be used in support of progressive realization of the right of access to malaria treatment. For example, where the state is being challenged by pharmaceutical companies not to utilize TRIPS flexibilities in order to tackle an emergency such as malaria, a public-spirited organization can intervene as *amicus curiae* in support of the state's case. Litigation is an important tool for demanding accountability from the state.[172] Once decision makers are aware that their actions or

[167] See for example Fuller, 1978. See also, Scott & Macklem, 1992.

[168] Id.

[169] Alston & Quinn, 1987. For arguments for and against socio-economic rights, see Mbazira, 2007. See also, Chirwa, 2005. South African jurisprudence has significantly weakened the argument that socio-economic rights are not justiciable. See for example *Soobramoney v. Minister of Health (KwaZulu Natal)* 1998 1 SA 765; *Government of the Republic of South Africa v. Grootboom* 2001 1 SA 46; *Ministry of Health v. Treatment Action Campaign* 2002 5 SA 72.

[170] On the socio-economic burden of malaria see section 1.1 of this paper.

[171] Busia & Mbaye, 1996.

[172] For a discussion of how litigation has for example been used by the Treatment Action Campaign (TAC) of South Africa to enhance access to medicines, see Heywood, 2005.

omissions are likely to be challenged in court, they may be more cautious, as has been observed by Etienne Mureinik:

> *[A]ny decision maker who is aware in advance of the risk of being required to justify a decision will always consider it more closely than if there were no risk. A decision maker alive to that risk is under pressure consciously to consider and meet all the objections, consciously to consider and thoughtfully to discard all the alternatives, to the decision contemplated. And if in court the government could not offer a plausible justification for the programme… then the programme would have to be struck down….* [173]

The Constitution allows any person who claims that his or her right has been violated to seek redress from court, including compensation.[174] The Constitution also provides for the concept of public interest litigation (PIL), whereby 'any person or organization may bring an action against the violation of another person's or group's human rights'.[175] PIL recognizes the vulnerability of disadvantaged persons or groups such as the indigent who may not be in position to file actions in their own names. A person is not required to have a personal interest or injury before lodging an application or petition alleging a violation of other persons' rights. Individuals or civil society organizations working for the public good can bring the violation or threatened violation of specific rights to the attention of the court.[176] Thus, the state can be challenged in court to show what steps it has taken to realize the right of access to malaria treatment. As pointed out above, the state has the burden of showing that it has used all the resources at its disposal to the maximum towards the realization of this right. The state would be required to devise a comprehensive and workable plan to meet its obligations in terms of the right of everyone to have access to malaria treatment. The state may be asked to explain how it plans to enhance protection of public health generally and access to medicines in particular.

The Constitution mandates the judiciary in Uganda to adjudicate civil, economic, political, social and cultural rights. Judicial power 'is derived from the people and shall be exercised by the courts…in the name of the people'[177] in accordance with their 'values, norms and aspirations'.[178] In the exercise of their power, 'the courts shall not be subject to the control or direction of any person or authority'[179] and 'no person shall interfere with the courts in the exercise of their judicial functions'.[180] All organs and state agencies must support the judiciary in exercise of its judicial functions.[181] The judiciary has a fundamental role to protect socio-economic rights such as the right of access to malaria treatment. Courts have the legitimacy and competence to adjudicate

[173] Mureinik, 1992, at 471.
[174] Article 50 (1) of the Constitution.
[175] Article 50 (2) of the Constitution.
[176] On public interest litigation in Uganda, see Mukubwa (2000).
[177] Article 126 (1) of the Constitution.
[178] Id.
[179] Article 128 (1) of the Constitution.
[180] Article 128 (2) of the Constitution.

socio-economic rights. The exercise of judicial power through the administration of justice certainly includes issues such as access to malaria treatment. The poor, who cannot afford malaria treatment, also aspire to live a life of dignity. It should also be noted that an activist court may expand rights such as the right to life, human dignity and non-discrimination to determine the obligations of the state to respect, protect and fulfill the right to health, including the right of access to medicines.

The Constitution also empowers the Human Rights Commission (HRC) to 'investigate, at its own initiative or on a complaint made by a person or group of persons against the violation of any human rights'.[182] It also has powers to recommend to Parliament effective measures to promote human rights.[183] Additionally, the HRC is enjoined to monitor the government's compliance with international treaty obligations.[184] The HRC has the powers of the High Court, and can summon witnesses and issue relevant orders against the state, its agencies and private persons in matters involving violations of human rights. The HRC should utilize its wide mandate to protect socio-economic rights generally and the right of access to malaria treatment in particular. This Commission could also require the state to periodically account as to the extent to which it is meeting its obligations to protect the right of access to malaria treatment, especially for the poor and vulnerable individuals and groups. This is in addition to actively following up the trade negotiations entered into by Uganda to ensure that they do not inhibit access to essential treatment. The HRC should put the state to task to explain why it has not met its reporting obligations under the ICESCR.

4.3 The Role of Civil Society

Civil Society Organizations (CSOs) engaged in traditional human rights work should extend their advocacy and activism to the economic and social arena. As such, they should be more directly engaged in poverty reduction processes by pressing the state to ensure that sufficient resources have been allocated to the health sector. CSOs should also follow up how the allocated money has been utilized especially for priority areas like malaria treatment. CSOs may challenge the state to demonstrate that it has used all the available resources at its disposal maximally towards the realization of the right of access to malaria treatment. At the same time, CSOs may spearhead public interest litigation. This is particularly important given that potential litigants may not be aware of their rights let alone being able to meet legal expenses.

[181] Article 128 (3) of the Constitution.
[182] Article 52 (a) of the Constitution.
[183] Article 52 (c) of the Constitution.

V. CONCLUSION

The right to health generally, and the right of access to malaria treatment in particular, have a firm foundation in international, regional and constitutional instruments. Although Uganda has tried to provide access to malaria treatment, it has not met all its obligations as laid out in international instruments. Neither the Uganda Constitution nor any legislation expressly provide for the right to health and its various components. There is a need for a framework legislation that reiterates the state's obligations to respect, protect, promote and fulfill the right to health. Such legislation should domesticate the norms and standards contained in the international instruments.

The state should be commended for developing a policy framework that targets vulnerable groups such as pregnant women and under-five children. However, the policy framework must cover all those individuals or groups who are unable for reasons beyond their control to realize the right of access to malaria treatment by the means at their disposal. Policy makers must incorporate a gender perspective in the design, implementation of programmes and interventions on malaria control. For these programmes and interventions to be meaningful, the intended beneficiaries must actively participate in their design, implementation, monitoring and evaluation. Any achievements made in the area of malaria prevention and treatment have been on the basis of external funding which is not sustainable since it exacerbates the foreign debt. This in effect undermines the state's capacity to progressively realize socio-economic rights such as access to malaria treatment. The state must prioritize expenditure of internally generated funds towards the promotion and protection of the right.

Uganda should devise appropriate mechanisms of utilizing the TRIPS flexibilities such as compulsory licensing and parallel importation. Since Uganda has a very low manufacturing capacity, it should adopt a regional approach through cooperation with the EAC countries, by pooling resources and sharing information in order to enhance access to pharmaceutical products. The struggle to promote and protect socio-economic rights must not be left to the politicians. CSOs and other human rights activists must litigate the right to health in order to compel the state to meet its obligations as spelt out in the relevant human rights instruments. The litigation process assists in placing issues on the agenda, both before the judge and the court of public opinion. Litigation can be used in challenging inappropriate state action, and addressing state inaction. Through litigation, both the state and non-state actors such as pharmaceutical companies can be held accountable for violations of the right to health. Finally, there is a need for a comprehensive study that determines the extent to which the poor and vulnerable actually access the malaria treatment provided by the state.

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