Regional Network for Equity in Health in east and southern Africa

DISCUSSION Paper NO. 118

Comparative review: Implementation of constitutional provisions on the right to healthcare in Kenya and Uganda

Centre for Health, Human Rights and Development (CEHURD)

In the Regional Network for Equity in Health in East and Southern Africa (EQUINET)

EQUINET DISCUSSION PAPER 118

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EXECUTIVE SUMMARY

The right to healthcare is a fundamental human right. It requires states to put in place policies and plans that will lead to available and accessible health services for their populace in the shortest possible time. Studies have shown the benefit to health in countries that have this right enshrined in their constitutions.

This discussion paper is produced by the Centre for Human Rights and Development (CEHURD) as part of the theme work on health rights and law of the Regional Network for Equity in Health in East and Southern Africa (EQUINET). The paper examines the implementation of constitutional provisions on the right to healthcare in Kenya and Uganda, two countries in East Africa. It aims to identify factors and mechanisms that have facilitated implementation of constitutional provisions on the right to healthcare, including how the constitutions were developed and framed. We compare implementation in Kenya, where the right to healthcare is explicit in their 2010 Constitution, and in Uganda, where the right to healthcare is implicit in the National Objectives and Directive Principles of State Policy.

The paper draws on two EQUINET case studies on implementation of constitutional provisions on the right to health, one each in Kenya and Uganda, published in 2018, a 2017 regional workshop that discussed the implementation of constitutional provisions on the right to health, and additional review of published literature. It presents a thematic analysis of the findings from the two case studies in terms of the judicial, political and popular implementation mechanisms, exploring further the factors and mechanisms that have facilitated or blocked their implementation. As the two constitutions address the right to healthcare differently, this analysis of their application provides insights into the factors and mechanisms for practice that may be useful in other settings.

Various international norms potentially supported implementation of the right to healthcare. Both countries have ratified most of the international instruments on the right to health, including the Universal Declaration of Human Rights (UDHR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Committee on the Rights of Persons with Disabilities and the Convention on the Rights of the Child (CRC). The two countries have also made regional commitments under the African Charter on Human and People's Rights (ACHPR) and the East African Treaty.

The two countries differ in how they implement these norms. Kenya has included in its constitution a provision to apply international law, that any treaty ratified by Kenya shall form part of the laws of Kenya. Uganda, in contrast, provides for a further demand to domesticate international law by first enacting it in local law. Nevertheless, the tabling by both countries of reservations on one protocol suggests that some ambiguity remains on this. Further, while the two countries have ratified the protocol to the ACHPR on establishment of an African Court, they have not deposited a declaration to the African Commission and therefore cannot take any cases on violation to this court, limiting the possibility of taking up these international commitments through this legal mechanism.

The paper highlights how different historical trajectories have led to constitutional inclusion of the right to health in the two countries, explicitly in the Kenyan Bill of Rights and implicitly in Uganda in the objectives. The eight-year constitutional reform process in Uganda was implemented through a widely consultative state commission process, but where there was limited demand for explicit inclusion of the right to health. The right to health in Uganda's current constitution is thus under the national objectives and directive principles of state policy where objective XX indicates that the state will take all practical measures to ensure the provision of basic medical services to the population. In Kenya the process was shorter, with a high level of involvement of strong Kenyan women's groups advocating for inclusion of reproductive health under the right to health. The right to health and healthcare are explicitly included in the bill of rights in Kenya's current constitution.

The constitution cannot implement itself. The issue of implementation was never part of the discourse on constitutionalism in Africa until the 2010 Kenya Constitution. The Kenyan government instituted a Constitutional Implementation Commission that provides valuable experience in how it steered implementation. We explore the implementation of constitutional provisions in the two countries in terms of three approaches: political, judicial and popular constitutionalism.

It would be expected that explicit provision of the right to health in the Kenyan Bill of Rights would make its implementation more likely, but this is not always apparent from the evidence found and reported in the paper, with various barriers raised to political, judicial and popular forces for implementation. The implicit provision in Uganda and proxy provisions such as the right to life were found to provide opportunities to be invoked to realize the right to health.

The findings suggest that a positive realisation is more visible in a judicial form of implementation, where judges and lawyers use both national and international doctrines on rights. In Kenya, the constitution provides for domestic application of such international norms. The right to health is clearly justiciable, and judicial officers have made rights-focused pronouncements in their judgements, including quotes of international law. In Uganda, where provision of the right is not explicit, a landmark case shows the complexity of judicial implementation. The Constitutional Court dismissed a case on the right to health as a political question, only to be overturned by the High Court following an appeal. In Uganda, while there is evidence of limited progress, legal ambiguity and a more limited understanding of the human rights approach amongst judges may have led to a variation across judicial officers in the interpretation of rights violations and challenges in litigating on human rights.

In both countries, we found challenges in the implementation of health policies that affect the implementation of rights, including weaknesses in accountability mechanisms, in decentralisation and resourcing of services and in people's social power to ensure that rights on paper are implemented in practice. This is even more pronounced where rights are contested, such as in the case of abortion services, where even constitutional provisions are not enough to advance such reproductive rights in the face of different forces, power interests and political dynamics facing health workers, communities and ministries of health who have a role in their implementation.

This raises the focus on popular mechanisms for implementation of health rights. Here too, while constitutional provisions have enabled and motivated social activism on the right to health, as found in Uganda, these processes need to be strategic and consider wider political perceptions and dynamics to avoid negative responses and even violation of other rights by law enforcers.

We suggest, therefore, that constitutional implementation cannot be achieved through one mode of implementation alone.

At the same time, common challenges to the implementation of constitutional provisions need to be addressed. They include the lack of provisions on accountability in legal frameworks, disempowered communities to hold government accountable and claim health rights, challenges with decentralisation and adequate financing of health services and lack of guidelines for co-ordinated implementation of multisectoral approaches.

Measures to address these constraints include: ensuring complementarity of laws, adopting international frameworks such as the OPERA framework to hold governments accountable, informing and empowering communities to claim their rights and adopting international guidelines to support implementation of multisectoral approaches.

1. INTRODUCTION

This discussion paper is produced by the Centre for Health, Human Rights and Development (CEHURD) as part of the theme work on health rights and law by the Regional Network for Equity in Health in East and Southern Africa (EQUINET). It reviews how Kenya and Uganda are implementing constitutional provisions on the right to healthcare to identify factors and mechanisms that have enabled implementation of constitutional provisions on the right to healthcare. The comparison is useful as Kenya has explicit provisions on the right to healthcare, while in Uganda these provisions are implicit in national objectives and directive principles of state policy.

The right to healthcare is a fundamental human right, requiring states to put in place policies and plans that will lead to available and accessible health services for their populace in the shortest possible time (Taket, 2012). Studies have shown the benefit to health in countries that have enshrined this right in their constitutions (Kavanagh, 2016). The public expenditure on health services that follows implementation of the right to healthcare is important because it can, if equitably allocated, support lower out-of-pocket spending on healthcare, expand coverage of priority health services and improve availability of medicines. Despite this, and the presence of several international and regional instruments advancing these rights, over half of the countries globally do not have the rights to health or healthcare enshrined in their national constitutions (Heymann et al., 2013).

General Comment 14 of the the International Covenant on Economic, Social and Cultural Rights (ICESCR) adopted at the 22nd session of the Committee on Economic, Social and Cultural Rights provides a detailed interpretation of the right to the highest attainable standard of health (UN, 2000) The General Comment provides that states have specific legal obligations to respect, protect and fulfill the right to health and provides guidance on the approaches through which this can be realised. These include health policy formulation, adoption of World Health Organization (WHO) guidelines, and adoption of specific legislation. While in some legal systems these obligations will have direct application at the national level, in other cases, as in Uganda, their application nationally depends on domesticating these rights and obligations by incorporating them into national law. The right to health covers determinants of health such as safe drinking water, adequate sanitation and healthcare, including health infrastructure, trained personnel and essential medicines as defined by the WHO. At regional level, the right to health is provided for in Article 16 of the African Charter on Human and Peoples Rights (ACHPR) (UN, 2008; OAU, 1982).

Constitutional provisions on the right to health can serve as powerful points of reference and advocacy tools for organisations working on the right to health within countries, given that the constitution is the supreme law in countries and sets the standard for all other laws, including public health-related laws. The legal text in a constitution is important for this, and for translating it into action. On its own, a constitution is full of general and often abstract principles. This means that further steps are needed to put its rights and duties into practice in terms that make sense to people's lives (Fombad, 2016). By definition, "constitutional implementation is a process designed to ensure the full, effective and continuous working of a constitution by promoting, enforcing and safeguarding it" (Fombad, 2016). The three arms of government — the executive, legislature and judiciary — implement constitutions. These institutions have duties, among others, to allocate resources, plan, provide and evaluate services. The executive (the president and cabinet) and the legislature are active and proactive, while the judiciary is mainly reactive. However, implementation cannot be left only to state leaders or officials. Citizens also have a responsibility to be aware of their rights, to hold officials to account, to share information and mobilise to claim their rights. Government roles are better realised when the citizens hold government institutions to account through civil activism.

This paper explores these issues by examining the implementation of constitutional provisions on the right to healthcare in Kenya and Uganda, two countries in East Africa. It aims to identify factors and mechanisms that have facilitated implementation of constitutional provisions on the right to healthcare, including in terms of how the constitutions were developed and framed. We compare implementation in Kenya, where the right to healthcare is explicit in their 2010 constitution, and in Uganda, where the right to healthcare is implicit in the National Objectives and Directive Principles of State Policy.

2. METHODS

We have used a grounded comparative review of two separate laws and country processes as it has the potential to contribute to inductive theory building. It allows for key concepts to emerge from a thematic comparison of descriptive case studies in each country by exploring similarities and differences between them. We analysed only two cases, Uganda and Kenya, due to the nature of the political phenomena under study and the need to understand the country context, history, national processes and experiences at some depth. Furthermore, given the limited resources for this work, an in-depth examination of the two countries was felt to yield more relevant evidence and analysis than a superficial analysis of many country cases in the region.

We thus used as input for the analysis two case studies developed in previous EQUINET work on implementation of constitutional provisions on the right to health in Kenya (KELIN, 2018) and Uganda (CEHURD, 2018), together with the discussion of these case studies by authors and stakeholders in a regional meeting on the right to health in Uganda (CEHURD, 2017). We carried out further searches and literature reviews to draw evidence on the issues that we found.

The Kenyan case study implemented by the Kenya Ethical and Legal Issues Network in HIV and AIDS (KELIN) explored the history of the right to healthcare before and analysis of the legislative framework for the right to health in Kenya's 2010 Constitution and in the jurisprudence on the right. The case study further presented challenges in the realisation of the right to healthcare in Kenya. The Kenya case study examined the differences constitutional rights to health have made in practice and the issues that have affected the capacity to claim and deliver on these rights (KELIN, 2018).

The Ugandan case study implemented by CEHURD reviewed international, regional and national law on the right to healthcare in Uganda, analysed the role of political, judicial and popular mechanisms in implementing constitutional rights to healthcare and the challenges in this implementation (CEHURD, 2018).

The regional workshop identified bottlenecks in implementing the right to healthcare and strategies for addressing them at national and regional levels (CEHURD, EQUINET, 2017).

Although the case studies had a slightly different scope and methods, they both included findings relevant to this paper. Thus, the paper presents a thematic analysis of the findings in terms of an analytic framework of the judicial, political and popular implementation mechanisms, to examine how the constitutional provisions on the right to healthcare in both countries are being implemented and the factors and mechanisms that have facilitated or blocked their implementation. As the two constitutions address the right to healthcare differently, this analysis of their application provides insights into the factors and mechanisms that may also be useful in other settings.

3. APPLICATION OF INTERNATIONAL COMMITMENTS ON THE RIGHT TO HEALTH

This section explores the extent to which international norms have supported implementation of the right to healthcare.

3.1 Application of international instruments

Kenya and Uganda have ratified similar international instruments relevant to the right to health; these include: the Universal Declaration of Human Rights (UDHR) (UN, 1948); the International Covenant on Economic, Social and Cultural Rights (ICESCR) (UN,1976); the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (UN, 1981); the Committee on the Rights of Persons with Disabilities; and the Convention on the Rights of the Child (CRC) (UN, 1990). This section provides a brief overview of the provisions of these instruments relevant to the delivery of health services, the social determinants of health and the protection of vulnerable people.

The UDHR supports implementation of the right to health through Article 25(1), providing for a standard of living adequate for the health and well-being of all, including food, clothing, housing, medical care, and security in case of sickness. Article 25(2) guarantees the special care and assistance for mothers, including the protection of all children, whether born in or out of wedlock. Article 27(1) encourages development of both traditional and biomedical health services in its provision of the right to freely participate in community cultures and to share the results of scientific advancements. Article 30 serves as a general protection of all rights as it prohibits any state, group or person from interpreting the UDHR in a way that infringes on any right (UN, 1948). Although a seminal document in international human rights law, the UDHR is not binding on member states but rather acts as a guide.

The ICESCR provides for the right to the highest attainable standard of physical and mental health, and details some actions for the state to realise these rights, such as by improving environmental and hygiene conditions, preventing, treating and controlling disease, and by national health insurance. By consenting to Article 2(1), signatories have agreed to utilise the maximum available resources to progressively realise the rights in it. The ICESCR covers the best interests of workers under Article 7(b) and provides for safe and healthy working conditions, while Article 10(2) entitles working mothers to paid leave before and after child birth and social security benefits. Articles 11(1) provide for the right to an adequate standard of living, including adequate food, clothing and housing, and their continuous improvement. Article 11(2) provides for freedom from hunger and obliges states, individually and through international co-operation, to improve the production, conservation and distribution of food through applying technical and scientific knowledge, disseminating information and through agrarian reforms (PWESCR, 2015). Having ratified the ICESCR, Kenya and Uganda have a duty to adopt qualitative and quantitative mechanisms to give citizens the most attainable level of healthcare possible. General Comment No. 14 further specifies the substantive issues arising in implementing ICESCR Article 12 on the right to health to provide 20 freedoms and entitlements relating to a wide range of socioeconomic factors that promote conditions for healthy life, and as determinants of health, as well as issues of health equity and discrimination:

> *The Covenant proscribes any discrimination in access to healthcare and underlying determinants of health, as well as to means and entitlements for their procurement. States have a special obligation to provide those who do not have sufficient means with the necessary health insurance and healthcare facilities, and to prevent any discrimination on internationally prohibited grounds in the provision of healthcare and health services.*(UN, 2000:para18)

General Comment 14, as for other such general comments, serves as an additional tool to assess state performance, and in this case requires healthcare to be available, accessible and acceptable and of good quality. The ICESCR is thus a means to be used in a number of complementary ways to advance the right to health in countries (PWESCR, 2015).

The CEDAW is an international agreement with similar intentions to the ICESCR but with a specific purpose to protect women. Article 11(1) entitles employed women to healthy and safe working conditions and paid maternity leave. Articles 11(2) and 11(3) aim to prevent discrimination against women on grounds of maternity by requiring states to prohibit unfair dismissals, introduce paid maternity leave or comparable social benefits, guarantee job security and periodically review protective laws in line with scientific or technological knowledge. Article 12 ensures equal access to appropriate health services including family planning, confinement, adequate nutrition during pregnancy and the postnatal period. For women in rural areas, Article 14(2) requires the state to encourage women's participation in setting plans and to provide women with access to adequate healthcare, medical information, counselling, family planning and health living conditions, including housing, water, sanitation, electricity and transport. The CEDAW supports gender equality through its promotion of women's rights to equal access to appropriate medical services and the highest enjoyment of the right to health. It thus offers potential for both Uganda and Kenya, being signatory to it, to use it to buttress their claims for better health (UN, 1979).

Children often receive specific attention in the application of rights. The CRC, to which both Kenya and Uganda are signatory, considers children's rights as an essential part of the right to health. Article 3 of the CRC establishes the primary considerations that must be taken in the best interests of a child to be put forward in deciding all matters. Article 6 recognises the right to life of every child and requests states to ensure the maximum development and survival of every child. Article 24(1) states that each child ought to enjoy the highest attainable standard of health and access to facilities for treatment of illness and rehabilitation. Article 24(2) sets a duty for each state to fully implement the right through appropriate measures to diminish infant and child mortality; provide necessary medical assistance, emphasising primary healthcare development; and combat disease, environmental pollution and malnutrition with technology, adequate food, clean drinking water and sanitation. The article sets a duty for states to provide mothers with appropriate prenatal and postnatal care, sensitisation on child health and nutrition and information on breastfeeding, hygiene, accident prevention and family planning (UN, 1990). Article 24(3) and (4) require the state to abolish traditional practices prejudicial to child health, such as child marriages. Articles 19 and 34 prohibit all forms of child abuse including sexual abuse, and demand that the state take the appropriate steps to protect children from sexual inducement, coercion, and exploitation in pornographic materials. These clauses are relevant both to Uganda and Kenya, where child poverty and maltreatment are important social concerns (UN, 1990). The CRC recommends that initiatives by the state be supported by international co-operation with due consideration of the needs of low-income countries (UN, 1990).

3.2 Regional instruments on the right to health

In Africa, the African Charter on Human and Peoples Rights (ACHPR) is today the most important human rights protection tool in Africa (OAU, 1982). It sets out human rights principles and notes that civil and political rights cannot be dissociated from economic and social rights. Article 16 specifically focuses on the right to health and the role of the state to uphold this right. The African Commission on Human and People's Rights, set up in 1987 and headquartered in Gambia, is responsible for interpreting the charter. The Commission holds sessions to handle cases brought before it by member states. As demonstrated in *Egyptian Initiative for Personal Rights and Interights v Egypt, the Commission* can identify violations of their rights set out in the ACHPR and the remedial actions to be taken by states, including submitting information to the Commission on measures taken to implement their recommendations (EIPRI, 2011).

Four protocols supplement the African Charter.

a. *The protocol to the ACHPR on the Establishment of an African Court on Human and Peoples' Rights* established the court in 1998 but the protocol only entered into force in 2004. Its jurisdiction extends to all cases and disputes presented before it by member states, in a process referred to as 'filing a communication', including cases on violations of the right to health (OAU, 1998). Twenty-four states have signed and ratified this protocol, including Kenya and Uganda. Twenty-five states have signed but not ratified and five states have neither signed nor ratified. The protocol requires that member states deposit a declaration to recognise the competence of the court to handle rights violations directly without going through the African Commission. Only non-government organisations and individuals

with observer status can proceed to file cases with this court. By 31 July 2013, only seven countries had deposited such a declaration. They include: Ivory Coast, Burkina Faso, Ghana, Malawi, Mali, Rwanda and Tanzania (Barrera, 2013), while Rwanda withdrew its declaration in 2016, claiming that persons convicted for crimes in-country should not access the court. This precedent challenged the legitimacy of the court and may deter states from depositing their declarations (Nyarko and Jegede, 2017). Kenya and Uganda have not deposited this declaration and therefore cannot take cases to the African Court. Kenya actually made an attempt in 2016 in a case where the Ogiek community sued the government for evicting them from their ancestral land in a bid to conserve the forest as a water catchment zone. The court could not hear the case because the state had not deposited the declaration. Instead, the case was forwarded to the African Commission (Barasa, 2016). In another example, Kenyan citizens challenged the Tanzanian government in *Wilfred Onyango Nganyi and 9 others v the United Republic of Tanzania* arising from a criminal case that had been pending in national courts for ten years. The court held that the applicants were not provided legal representation, which denied them a right to a fair hearing, as provided for in the ACHPR (Nyarko and Jegede, 2017). Approximately 118 (70%) cases handled at this court are from Tanzania, the host country for the court and one that has deposited the declaration (Barasa, 2016). No case was found on the right to health.

b. *The protocol to the ACHPR on the Rights of Women in African (Maputo protocol)* recognises the role of women in development, as is found in international human rights instruments. It also recognises women's role in preserving African values, the vulnerability of women as victims of discrimination and harmful practices and refers to ACHPR provisions on equality and elimination of discrimination, amongst others. Article 14 of the protocol focuses on health and reproductive rights. It has two general comments, one on sexual and reproductive health rights and one on the role of state. Under the second, both Kenya and Uganda put a reservation on 14(2)c that obligates states to protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest and where the continued pregnancy endangers the mental and physical health of the mother or life of the mother or the foetus (AU, 2003)

c. *The protocol to the ACHPR on the Rights of Older Persons defines older persons* as individuals aged 60 and above and aims to protect their rights. It obliges states to adopt the UN principles of dignity, self-fulfilment, participation and care in their national laws. It prohibits all forms of discrimination and explicitly promotes protection from violence, sexual abuse and discrimination based on gender. Additionally, it promotes access to healthcare for older persons. This protocol was adopted in 2016, but only five member states have signed it to date and no member state has yet ratified it (AU, 2018; Nyarko and Jegede, 2017). It can only come into force 30 days after the fifteenth member state has ratified. Neither Kenya nor Uganda have signed the protocol. At the 2016 Summit of the African Union (AU), the Regional Director of HelpAge International, based in Kenya, called on African heads of state to adopt and ratify the protocol and deposit it with the AU Commission (HelpAge, 2016). Thirty-four other civil society organisations working with older persons across the continent endorsed this call. HelpAge International, a non-government organisation (NGO) with a mandate to support the rights and wellbeing of older persons, received endorsement from more than ten organisations from Kenya and Uganda (HelpAge, 2016). Their advocacy efforts have not yielded any commitments from Kenya or Uganda, but the Centre for Human Rights at the University of Pretoria has launched a campaign '#AgeWithRights' to strengthen advocacy around rights of older women and to advocate for states to ratify the protocol (University of Pretoria, 2018).

d. *The protocol to the ACHPR on the Rights of Persons with Disabilities in Africa* aims to protect the rights of persons with disability, given their experience of rights violations, discrimination, social exclusion and prejudice. Article 17 provides for their right to health, including sexual and reproductive health (AU, 2016). The 2018 AU summit in Ethiopia adopted this protocol, and the special rapporteur on the rights of persons with disabilities called on all 53 states that signed the ACHPR to ratify it (UN, 2018). No state has yet done so, but a regional meeting in Uganda in 2017 promoted the protocol with

delegates from South Africa, Tanzania, Sudan, and Burundi. Kenya was not among them (Nampala and Odeng, 2017). The progress from this meeting is not known.

Both Kenya and Uganda have committed to regional instruments relevant to the protection of the right to health in East Africa. These include the Treaty for the Establishment of the East African Community (EAC), which in Article 117 obliges member states to co-operate in various matters including health, and in Article 118, which urges partner states to promote the management of health delivery systems to enhance the efficiency of their healthcare systems. Under the EAC, countries have committed to jointly working towards prevention and management of infectious and non-infectious diseases; epidemics and pandemics that might threaten the health of the community; and to co-operating in public health campaigns such as mass immunisation (EAC, undated). The EAC has held strategic meetings to support implementation, such as one to improve regional preparedness following the recent Ebola outbreak in the Democratic Republic of Congo (EAC, undated). In a two-day retreat in Uganda in 2018 , EAC heads of state committed to two goals: the first to improve cross-border healthcare by expanding access to specialised care and cross-border health services in the region; and the second to strengthen the network of medical reference laboratories and the regional rapid response mechanism to protecting the region from pandemics, bioterrorism and common agents. This commitment was read in a communiqué signed by the presidents of Uganda, Kenya, Tanzania, and South Sudan, and by representatives of the presidents of Rwanda and Burundi (Ssali, 2018). This commitment indicates a political intention that now needs to be put into practice.

Within the EAC, five technical working groups have been formed: medicines and food safety; control and prevention of STIs, HIV and AIDS; control and prevention of communicable and non-communicable diseases; health research, policy and health systems development; and reproductive, adolescent health and nutrition. The East African Health Platform, created under the EAC Treaty, provides a collaborative space for representatives of private sector organisations, civil society organisations (CSOs), faith-based organisations and other interest groups in East Africa to contribute to health and development in the region. The East African Health Platform vision is of a healthy and productive population that can access local, acceptable and affordable healthcare. Efforts to realise this vision were made under projects such as Platform's five-year maternal infant health strategy aimed at reducing maternal and newborn mortality rates in East Africa by 2020 (Ligami, 2015).

A further treaty implementation mechanism is the East African Health Research Commission, which aims to improve the provision of affordable and quality healthcare services in the region through research and capacity development for health and knowledge management. It has established the *East African Health Research Journal* and a Regional East African Community Platform Policy Initiative (REACH) in 2005, with the latter having influenced Uganda to publish policy dialogue reports (East African Community, undated).

Various other regional initiatives on law have also played a role in health, including the 2012 East African Community HIV and AIDS Prevention and Management Act, a regional intellectual property policy on the utilisation of public health-related WTO-TRIPS flexibilities and support for national intellectual property legislation. In revising its Industrial Property Act, Uganda included some WTO-TRIPS flexibilities including: compulsory licensing (Sec 66), which enabled government to use a patent without the owner's permission where there is public health interest; recognising exemption of pharmaceutical products from patenting during the LDC waiver (Section 8(3)(f)); and allowing use of patented invention without authorisation for experimental research (Section 44), including use of clinical data after approval from National Drug Authority (NDA) (Govt of Uganda, 2014).

Many of these international and regional instruments that Uganda and Kenya are signatory to have encouraged the two countries to make national efforts to improve healthcare services. However, there is no evidence that they have created the accountability systems needed for their implementation.

3.3 Domestication of international instruments

One issue that affects the implementation of these international norms is whether they apply automatically in countries or need to be domesticated. The 1969 Vienna Convention on the Law of Treaties permits states to voluntarily join a treaty, after which it must observe and discharge the treaty obligations (Ahmed-Hameed, 2016). In a monist system, countries can domesticate international treaties without enacting or adopting new statutes. In this case, once a state ratifies an international instrument, it automatically becomes part of national law (Kabau and Ambani, 2013).

Additionally, despite this unity of international and national law, one system has supremacy over the other, either international or domestic law. In the event of a conflict between them, reference is made to national law to decide which legal system prevails over the other, as to whether international law prevails over national law or vice versa would be set in national law (Kabau and Ambani, 2013). Alternatively, in a dualist system, international law and national law may be regarded as two independent, autonomous systems. In this circumstance, once a state ratifies an international instrument, then it needs to domesticate it in national law for the international law to apply (Kabau and Ambani, 2013).

In Uganda, the situation is governed by the Constitution and the Ratification of Treaties Act (Rep of Uganda, 1995). In the former, a 2005 amendment requires the state to be guided by national objectives in applying or interpreting the constitution, passed to ensure a just, free and democratic society. At the same time, foreign policy aims to respect international law and treaty obligations, which can override local laws. Courts of law can invoke this provision to accord benefits of international treaties to individuals (Musota, 2015).

Since the promulgation of the current constitution, Uganda can only conclude treaties only after the attorney general has provided legal advice. Cabinet ratifies treaties except for those on armistice, neutrality, peace or the subject of which requires constitutional amendment. In this event, ratification is by Parliament. The attorney general must table all ratified treaties with Parliament. The Minister of Foreign Affairs executes all ratified treaties and has the mandate to deposit them. The requirement for the attorney general to present the ratified treaty to Parliament for domestication means that Uganda applies the dualist system (Musota, 2015).

In Kenya, before promulgation of its 2010 Constitution, the country was also under a dualist system. While the country had ratified many international instruments, there was no clarity on which treaties bound the state, as the previous constitution had no provision on how international law was to be domesticated (KELIN, 2018). In contrast, the 2010 Constitution in Article 2(5) states that the general rules of international law shall form part of the law of Kenya. Article 2(6) emphasises that any treaty ratified by Kenya shall form part of the laws of Kenya (KELIN, 2018).

This suggests a monist system is now in place. However, Article 21(4) of the 2010 Constitution also obliges the state to enact and implement legislation to fulfil its international obligations in respect to human rights and fundamental freedoms, which signals that the dualist system applies (Jama, undated). Some scholars have thus raised concern that the relationship between international law and national law is uncertain, and in situations of conflict the hierarchy of what law prevails is unclear (Kabau and Ambani, 2013).

These concepts and issues are discussed in the next section in relation to how the constitutional provisions on the right to healthcare have been applied in Kenya and Uganda.

4. CONSTITUTIONAL PROVISIONS ON THE RIGHT TO HEALTH IN THE REGION

Many African countries that were under British colonial rule lacked a robust Bill of Rights and socioeconomic rights, including the right to health, in their constitutions (Munene, 2002). In this section we examine how the constitutions provided for health, before and after constitutional reforms.

4.1 Previous constitutional provisions on the right to health

Both Uganda and Kenya have undergone a number of constitutional changes. As outlined below, early legal provisions in both countries appeared to be driven primarily by epidemic and disease control concerns, with no consideration of rights to healthcare. Post-independence legal and healthcare reforms took on wider issues, but with political interests overshadowing health in legal reforms.

Following a rule by monarchy in pre-colonial Uganda, Orders of Council were applied during the colonial era between 1894 and 1962. The first Order of Council in 1902 set up a centralised system of governance with an executive, legislature and judiciary (Mukholi, 1995). Traditional rulers resisted this system, and it was scrapped almost on Uganda's independence in 1962. The 1963 independence constitution provided for a federal system with a cultural ruler serving as head of state and of kingdom (Mukholi, 1995). In this constitution (Section 7), Parliament had powers to make laws on medical, health and veterinary services, including mental treatment, poisons and dangerous drugs, and control of both human and animal diseases (Buganda.com, undated).

This constitution was revoked in 1966 by the then-Prime Minister Dr Milton Obote, who declared himself president under an interim constitution. In 1967 a Republic Constitution replaced the interim constitution, abolishing federalism and returning to central governance. Four years later in 1971, General Idi Amin seized power and ruled by constitutional decree until 1979 when he was overthrown. Dr Obote was elected president in 1985 in a term that lasted only one year. None of these later constitutions had provisions on health, although the 1967 constitution had a section establishing fundamental human rights. Nevertheless, the government at the time did not protect, fulfil or respect human rights or the rule of law (Ssekandi and Gitta, 1994; Fombad, 2016).

Healthcare also evolved over time. In 1889, medical services were only provided for British colonialists working in Uganda. Services were extended later to the local population in response to successive epidemics of plague, syphilis, sleeping sickness and small pox (Sserwanga, 2013). Missionaries started medical services for local communities from 1897, first with a hospital at Mengo and then health centres at Mulago, Mityana and Masaka to treat sexually transmitted diseases that migrants from Europe and India brought to Uganda (Sserwanga, 2013). By 1970, the country had 49 hospitals that also acted as teaching institutions for health workers. In the political instability of 1971–1985, the public health infrastructure declined and many health workers emigrated (Sserwanga, 2013). This led to a rise in private sector services, including many illegal clinics and unregistered medical practices. Poor observance of the rule of law as a whole and lack of concern for people's health undermined regulation.

Kenya was declared a British protectorate in 1920 and, like Uganda, colonial rule was by decree and ordinances. Unlike Uganda, Kenya's independence constitution was centralised, ignoring the traditional structures that existed before colonialism (Khamadi, 2015). There was a focus on nationalism and the interests of the populace, giving health higher importance than in Uganda, where power interests made federal systems take precedence (Mukholi, 1995).

After Kenya's independence in 1963, Sessional Paper number 10 on 'African Socialism' was enacted to drive nation-building and socioeconomic development. This paper included measures for elimination of disease, poverty and illiteracy and included a health policy that set a goal for universal coverage of healthcare. The policy abolished the user fees that applied during colonial rule, with health services funded from general taxation and delivered through the Ministry of Health (KELIN, 2018).

Unfortunately, power and political interests in Kenya also became dominant. By 1969, the independence constitution had been amended ten times, giving increasing power to the presidency (Khamadi, 2015). While policy commitments had been made on ensuring health for all, the constitution did not have explicit provisions on the right to healthcare, although it conferred powers on the state to control individual rights in the interest of public health (KELIN, 2018). Various legal reforms were implemented to regulate healthcare including: the Nurses Act of 1983; the Public Health Act of 1983 stipulating the role of the state in public health; and the Clinical Officers (Training, Registration and Licensing) Act of 1988. In 1988, user fees were re-introduced due to poor national economic performance and, with influence of the International Monetary Fund, declining budgets to healthcare (KELIN, 2018). Various laws were passed to respond to emergent challenges, such as the HIV and AIDS Prevention and Control Act 2006 that provided comprehensive measures for prevention and control of HIV/AIDS, but also included protection of the rights of persons living with HIV (KELIN, 2018).

In both countries, global developments in the 1990s, the end of the Cold War and an international drive for good governance and democracy motivated pressures for constitutional reform. In Kenya, civil society and political actors advocated for and initiated dialogue on constitutional reform. After the post-election violence in 2007, processes were put in place for this and a new constitution was promulgated and entered into force in August 2010 (Fombad, 2016).

In Uganda, constitutional reform was motivated by the political conflict of the 1970s to 1985. In 1986, when the National Resistance Movement (NRM), the current ruling party in Uganda, took over power it enacted Statue 5 of 1988, authorising constitutional reform led by an elected constituent assembly. In September 1995, the current Uganda Constitution was promulgated. For the first, time it made explicit provision of the rights and entitlements of Ugandan citizens.

4.2 The constitutional reform process and the right to health in Kenya and Uganda

In both Kenya and Uganda, the processes for the drafting of the current constitutions are reported to have been highly participatory. In Uganda, a process that was singled out as being unique in Africa involved a seven-year consultation in which the Constitutional Commission, the body mandated to oversee the process, received more than 25,000 separate submissions (Fombad, 2016).

In Kenya, a draft constitution was shared with the public in November 2009, with 40,000 responses to this and about 1.7 million substantive recommendations (Lwabukuna, 2017). Kenya's highly inclusive process highlighted a demand for the right to health and led to the inclusion of the right to reproductive health for women, absent from the earlier draft (Lwabukuna, 2017). There is no evidence of a similar demand or inclusion in Uganda.

These constitutional reform processes were taking place at a time when efforts were underway to re-build health systems. In Uganda, a Health Policy Review Commission set up in 1987 generated a strategy for rehabilitation of existing health infrastructure and establishment of primary healthcare services. The Ministry of health developed its first ten-year National Health Plan 1990–2000 to: recommit to primary healthcare; promote community participation through health committees; reorganise the health system and decentralise healthcare; promote intersectoral collaboration and co-ordination between ministries, NGOs and funders; promote and regulate private practice; integrate traditional medicine into the national health system and promote alternative methods to improve health financing (Sserwanga, 2013).

After debate with external funders on the mismatch between plans and funds, a new policy was prepared in 1995 that limited further expansion of healthcare infrastructure, restored functioning to existing health facilities, reoriented the health system to primary healthcare, but with a basic healthcare-package approach based on needs and available resources and user-fees for health financing.

The intersect between this health policy process and the Ugandan constitutional reform process suggests that health and healthcare were not viewed as substantive rights to be included in the Bill of Rights, despite ratification of the ICESCR in 1987 and the rights to health it covers, as noted earlier. This international guidance was ignored during the drafting of the constitution, while the participatory process may not have included voices of those in civil society or political parties claiming these rights, with women's movements and other social movements weak or absent at the time of the constitutional reform (Fombad, 2016). In Uganda, the right to healthcare was thus placed under the national objectives and directive principles of state policy as a non-enforceable aspiration.

In Kenya, in contrast, health was already a priority in the independence constitution and recognised as an enforceable right. The constitutional reform process in Kenya aimed to be inclusive and to enhance equality of voice. A powerful and vocal women rights' movement seized that opportunity to challenge structural and gender-based violence and discrimination and to advance their agenda, including health and reproductive health rights (Lwabukuna, 2017).

The 2010 Kenyan Constitution reflected these active roles in the in constitution-making process, in the inclusion of reproductive health rights and rights to healthcare in the Bill of Rights. Uganda's process, while consultative, focused more on civil political rights, leaving social and economic rights such as rights to health as national objectives and directive principles of state policy. The nature of an engagement in the constitution-making process appears to have played a key role in shaping the final contents of the constitution in relation to health rights.

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4.3 The current constitutional frameworks and the right to health

Hence, while both the Kenyan and Ugandan constitutions provide for a Bill of Rights, only the former includes the right to healthcare in its Bill of Rights.

The Constitution of Kenya 2010, Article 20, states that the Bill of Rights is applicable to all laws and binds all state organs and persons, and that every person enjoys the rights and freedoms captured in the Bill of Rights to the greatest extent consistent with the nature or the right or fundamental freedom (KELIN, 2018). In Uganda, Article 20(2) of its constitution has a similar effect as it imposes a duty on all government organs, agencies, and persons to respect, promote and uphold all human rights.

The 2010 Kenya Constitution, however, includes guarantees of the right to health under Article 43(1)(a). It states that "every person has the right to the highest attainable standard of health which includes the right to healthcare services, including reproductive healthcare." Article 43(2) provides further that a person shall not be denied emergency medical treatment. It spells out the obligations of the state, including setting of standards to achieve the progressive realisation of the rights guaranteed therein. The constitution provides further that all state organs and public officers have the duty to address the needs of vulnerable groups within society, including women, older members of society, persons with disabilities, children, youth, members of minority or marginalised communities, and members of particular ethnic, religious or cultural communities. It further mandates courts, tribunals and other authorities to interpret the law in event of violations (KELIN, 2018).

In Uganda, the bill of rights guarantees the citizens their inherent entitlements but does not expressly stipulate the right to health. It provides for state commitments to provide basic medical services as an objective (#10). The Constitution has provisions on the right to life, to a clean and healthy environment, and rights of particular groups, including women, child and persons with disabilities and freedom from torture that are related to health (CEHURD, 2018).

This non-explicit nature of the right to health in Uganda complicates its justiciability as evidenced by Constitutional Petition 16 of 2011. In this case, civil society filed a suit in the Constitutional Court against government for its failure to put in place systems to prevent maternal deaths in public health facilities. This failure was argued to be a violation of the right to the highest attainable standard of health as stipulated in the national objectives and other constitutional provisions, including the rights of women (CEHURD, 2018).

The Constitutional Court argued that judging on the issues raised in the petition implied taking over the role of the government executive and that the injustice was not a constitutional, but a political issue. The Court was reluctant to hear the matter because it assumed no power to enforce its jurisdiction on matters that require analysis of the health sector (CEHURD, 2018). The Constitutional Court thus dismissed the case. However, in an appeal to Uganda's High Court the dismissal was struck down, with a ruling that the Constitutional Court had erred and that it indeed had a mandate to hear the case (CEHURD, 2018). The case was sent back to the Constitutional Court and a date was set for a hearing on 28 April 2018. Because one judge was not present the court adjourned and a new date has not been set at the time of writing this paper.

The example of abortion provides a useful lens through which to explore the way the two constitutions address application of health rights. Both countries have similar legal provisions on the right to life. In Kenya, abortion is not permitted under article 26 (4) of the Constitution unless, in the opinion of a trained health worker, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law (Lwabukuna, 2016). Similarly, Article 22 (2) of the Ugandan Constitution states that: "No person has the right to terminate the life of an unborn child except as may be authorised by law" (Mulumba et al., 2017).

Both constitutions thus permit abortion but under circumstances contained in written law. In Uganda, the Parliament has not yet made such law (CEHURD, 2018). In Kenya, however, the clause "permitted by any other law" is taken to indicate that abortion is permitted, because, as set in Section 3.2, Kenya applies a monist system considering international law to be part of Kenyan law. Hence Article 12 of CEDAW may be understood to be the "other law" permissible for abortion (Lwabukuna, 2016).

While this difference in legal systems may imply that the two countries differ in how they interpret the constitutional provisions on abortion, controversy persists. As noted earlier, when the Maputo Protocol was ratified in October 2010, shortly after promulgation of the new Kenyan Constitution, both Uganda and Kenya put a reservation on Article 14 (2)(C) that provides for abortion. On the one hand, in Uganda, this could be interpreted through its processes for domestication of international law, and in Kenya the action may be seen to contravene the commitment to uphold international law. On the other hand, it may also be seen to be in line with the provision in the constitution on domestication raised earlier. The ambiguity presents a challenge for both lawyers and judicial officers in interpreting the law.

The penal codes in both countries codify punitive action for the woman who procures the abortion, the health providers that conduct the abortion and any third party that provides any substance for abortion (Lwabukuna, 2016; CEHURD, 2018). Both penal codes have similar clauses on exemptions from this provision.

In Uganda:

> *A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation…upon an unborn child for the preservation of the mother's life* (Mulumba et al., 2017).

Likewise in Kenya:

> *A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all the circumstances of the case* (Mulumba et al., 2017).

Further, the phrase 'trained health worker' in Kenyan law has been interpreted to mean that a varied cadre of health professionals can provide the service indicated, such as the provision of medical and surgical abortion by trained midlevel health providers (Lwabukuna, 2016; Renner, 2013). However, in both laws the understanding of what constitutes the threat to a woman's life may be limited, not considering the longer term threat to women's health from rape, incest, fetal impairment or poverty (Lwabukuna, 2016; Mulumba et al., 2017).

The Kenyan Penal Code provides that if a professional performs an abortion, the woman and her spouse (if married) must give their consent. Yet this violates women's right to reproductive choice (Lwabukuna, 2016). While the section on consent is absent in the Ugandan Penal Law, the broader restrictions are used in practice where law enforcers view abortion as illegal and, consequently, see incarceration as the punishment for those involved. Health workers thus fail to provide life-saving abortion services for fear of punishment and public ridicule (Mulumba et al., 2017). This leaves women to seek unsafe services from untrained persons in clandestine environments, a factor that contributes to maternal morbidity and mortality (CEHURD, 2018).

Ugandan advocates have appealed to government to revisit the law on abortion, clarify the legal criteria to prevent deaths due to unsafe abortion and to protect health workers from the risk of prosecution (CEHURD, 2018). In Kenya, where the 2010 Constitution is more permissive than the existing laws on abortion, these laws still need to be aligned with the constitution (Lwabukuna, 2016).

Hence, while both the Ugandan and Kenyan constitutions include access to healthcare as a desirable outcome, the Kenyan Constitution has gone further in explicitly providing for the right to health and healthcare in the bill of rights. While Uganda's legal and constitutional regime remains conservative, Kenya may offer useful lessons on the benefits and challenges for implementation associated with a more explicit provision for the right to health. The discussion on abortion points to some of the difficulties with applying these rights even when formalised in relation to specific health issues like abortion services, despite this being a key public health problem. The next section explores implementation of these different constitutional norms.

5. IMPLEMENTATION OF CONSTITUTIONAL PROVISIONS IN THE REGION

As Fombad (2016) rightly puts it, the constitution cannot implement itself. The issue of implementation was largely ignored in the African discourse on constitutionalism until the advent of the 2010 Kenya Constitution. In this paper, we explore three forms of constitutional implementation, that is popular, political and judicial constitutionalism with the policy, institutional and administrative reforms they lead to (Gerirtz, 2015; Fombad, 2016). In this paper we use the definitions below for 'constitutional implementation'.

Popular constitutionalism refers to the interpretation and enforcement of the law by the people. In Uganda and Kenya that the constitutions belong to the people and reflect people's desires is reflected in the preamble, "we the people." In the event that the constitution is violated, the people have a mandate to protest and defend it, as individuals and civil society. The media can play a role in investigating and reporting violations to increase public awareness, while legal experts can be a watchdog for the rule of law and can defend those with less knowledge of the law (Fombad, 2016; Gerirtz, 2015). Others who may play a role include businesspersons or technical activists with knowledge of human rights issues.

Political constitutionalism refers to enforcement of the constitution by the executive (the president) and the legislature. This may include opposing or refusing to vote for law that violates the constitution, or, in the event such law is passed, then for the president to reverse this decision.

Judicial constitutionalism is the most common form of constitutional implementation worldwide. It is based on the premise that the constitution is the supreme law and that it is the mandate of the courts to apply the law. No law can take precedence over the constitution and constitutional provisions can nullify law. While political constitutionalism may be biased to advance specific interests the judicial process acts to control this.

5.1 Political constitutionalism of the right to health in Kenya and Uganda

The constitutions in Kenya and Uganda provide for establishment of executive, legislative, and judicial arms of government. They put limits on executive (presidential) powers and checks and balances between different arms (Fombad, 2016: 276; CEHURD, 2018; KELIN, 2018). For example, in Uganda Parliament checks presidential powers by examining the presidential nominations for ministerial roles. Likewise, the President has to assent to bills passed by Parliament before they become law (CEHURD, 2018).

For both countries, the political will to formulate, implement and oversee health policy is important to realise the right to health. In this respect, their development agendas are guided by the Kenya Vision 2030 and Uganda Vision 2040, as implemented through policies, national and sectoral development plans (CEHURD, 2018; KELIN, 2018). These 'vision' documents apply a human rights-based approach to all programmes, including health, and all recognise health as underpinning their socioeconomic transformation. As noted earlier, while both countries promote public participation in delivery of healthcare, the legal frameworks on health in Kenya are explicit on the right to health, while those in Uganda are not, although they promote respect for human rights in the provision of care (CEHURD, 2018; KELIN, 2018).

The Kenyan Government set up a Constitutional Implementation Commission to oversee implementation of its constitution for the first five years. During this period, the Commission passed 18 pieces of legislation to restructure the judicial system, to establish various commissions and institutions and to prepare for the first elections held under the 2010 Constitution. The Commission is reported to have applied a professional approach, despite problems of piecemeal interpretation of the constitution, political tensions and report of presidential interference. It has been argued that the model is worth adapting for specific contexts (Fombad, 2016).

In relation to *decentralisation of health services* both constitutions provide for devolution of powers, implying the decentralisation of public decision making (CEHURD, 2018; KELIN; 2018). Like other services, health is decentralised through 47 county governments in Kenya and 127 district local governments in Uganda. Both countries face challenges of a lack of knowledge and skills to implement this decentralisation. In Kenya, this affects absorption of funds allocated for healthcare. In Uganda, the late disbursement of funds from the Ministry of Finance to the district local governments, especially in rural areas, further affected this weakness; and in Kenya the stringency in development partner agreements was a factor (KELIN, 2018). The public health sector is underfunded in both countries which, combined with misappropriation of funds and theft of resources and a lack of accountability frameworks besides courts of law, undermines delivery on healthcare.

Nevertheless, both countries are beneficiaries of an initiative to improve decentralised service provision - Global Financing Facility (GFF). The GFF was developed in 2015 following a conviction by the World Bank that 'business- as-usual' is not enough to close the annual funding gap of US$ 33.3 billion to meet the Sustainable Development Goal targets for Reproductive, Maternal, Neonatal, Child, Adolescent Health, and Nutrition (RMNCAH-N). Through the GFF, donors and foundations make financial commitments that the World Bank invests on their behalf to accelerate gains in RMNCAH-N in 67 of the world's poorest countries. For each $1 of investment, willing countries must commit to $4 financial credits on concessional terms that involve loan repayment terms at very low interest rates or with long grace periods (Kiiza et al., 2018). Kenya and Uganda received $40 million and $30 million, respectively, as a grant from the GFF trust fund through this mechanism. This was matched with $150 million and $110 million, respectively, as loans (World Bank, 2017).

The GFF theory of change is linked to results-based financing (RBF) whereby providers are paid after realising predefined indicators for improvement coverage and quality of maternal, child and adolescent health services. The decentralised health facilities are directly funded, unlike before when funds were channeled through the district in Uganda or county government in Kenya. As such, the provider controls the resources and this has been reported to contribute to clarity of budget needs, quality of services and improved health outcomes. (Kiiza et al., 2018). For RBF to be effective, certain assumptions are made. These include prior existence of a functional health delivery system, service providers who have technical capacity to deliver, and an enabling political economy. The only missing variable in health service improvements is the incentivisation of the service providers by the government. Unfortunately, these are not consistent with the realities in developing countries such as Kenya and Uganda (Kiiza et al., 2018).

a. *Legislation on reproductive choice*

The stance on abortion in both countries is similar as they both made political decisions to put a reservation on the related provision in the Maputo Protocol. This may be because both countries have restrictive abortion laws dating back from colonial times (Cleeve et al., 2016). In 2012 and 2015, the ministries of health in Kenya and Uganda developed standards and guidelines on reduction of maternal mortality and morbidity due to unsafe abortion. Unfortunately, these were withdrawn in 2013 in Kenya and in 2016 in Uganda following disagreements on content by different stakeholders (Cleeve et al., 2016).

The subject remains contentious in both environments. This situation highlights the challenges that the ministries of health encounter in implementing technical areas that advance the right to health in highly conservative and political environments. In Uganda, the case study highlights that women's health issues have generally not been prioritised mainly because the decision-making structures at national and subnational level are largely patriarchal with less commitment to women's issues. The contention extends to provision of family planning services for sexually active young people, including provision of sexuality education and healthcare access for LGBTI groups (CEHURD, 2018).

b. *Multisectoral approaches*

The health policy frameworks in both countries promote the involvement of other ministries and sectors to realise the right to health. Kenya has adopted such an approach for improving adolescent health through collaborations with other sectors such as education and gender with the health sector (World Bank, 2018). The Kenyan case study also highlights Siaya County efforts to address malaria as an example of a best practice. Through a multisectoral approach, the prevalence lowered from 42% to 20% (KELIN, 2018). In Uganda, the Health Sector Development Plan (HSDP) calls for a multisectoral approach with other sectors such as local governments, the ministry in charge of disaster preparedness to co-operate in the delivery of the Uganda Minimum Healthcare Package (MoH, 2015). Unfortunately, there is no guidance for supporting a co-ordinated approach, including how the different ministries collaborate. Similarly, the Kenyan health policy strongly promotes the multisectoral approach and, although there are the examples as shown above, there does not seem to be guidance on this approach (KELIN, 2018).

A multisectoral approach can help pool resources, share knowledge, co-ordinate responses and overcome duplication of efforts and bottlenecks in the implementation of health programmes (Salunke and Lal, 2017). Yet in Uganda, CEHURD has taken the government power distribution company and the Electricity Regulatory Authority (ERA) to court over avoidable patient deaths from load shedding in public hospitals. The case reflects that while commitments to multisectoralism exist on paper, such as between the health and energy ministries, implementation is incomplete (Wesaka, 2012).

Hence, while Uganda and Kenya have differing constitutional provisions on the right to health, they have similar health plans and share similar implementation issues. The evidence points to gaps between the formal commitments in official documents and the governmental financial and resource allocations in practice in relation to healthcare. In both countries, efforts need to be made beyond establishing these formal commitments and constitutional amendments to ensure their implementation in practice.

A constitutional provision for the right to health could allow for additional accountability mechanisms that can contribute to this, while noting that such mechanisms face power conflicts when formal constitution and legal commitments are disregarded at political level. The next section explores the role of the judiciary in this.

5.2 Judicial constitutionalism of the right to health in Kenya and Uganda

The right to health in Kenya became clearly justiciable after promulgation of the 2010 Constitution. The first case, *PAO and others v Attorney General,* challenged sections of the 2008 Anti-Counterfeit Act. This law provided a broad definition for counterfeit goods but posed a risk that generic lifesaving HIV medication would be included, giving law enforcers the power to confiscate such medicines. The court held that a lack of availability of these essential lifesaving medicines would have adverse consequences for the right to health, dignity and life. Following this, in cases brought by different actors, judges have used the rights language in their judgements, including quotations of international doctrine, in developing jurisprudence on the right to health.

The cases across both countries demonstrate how different judges interpreted health rights violations. *KELIN and Others v The Cabinet Secretary for the Ministry of Health and Others* challenged a presidential directive for its intention to collect up-to-date data on school going children living with HIV, their guardians, expectant mothers living with HIV and breastfeeding mothers living with HIV. The petitioners cited this as raising the risk of stigma and discrimination and a violation of rights to health, privacy, equality, freedom from cruel, inhuman and degrading treatment and the principle of the best interest of the child. In the judgement, the court ruled that the right to privacy was violated but not the right to health and, in contrast, added that the directive aimed to fulfil the right to health (KELIN, 2018).

In Uganda, on the other hand, justiciability of the right to health first came into the public domain during the Constitutional Petition 16 of 2011. In this case, civil society petitioned against government in the Uganda Constitutional Court for its failure to put in place systems to prevent maternal deaths in public health facilities. This failure was argued to be a violation of the right to the highest attainable standard of health. In response the judgement stated:

> *...Much as it may be true that government has not allocated enough resources to the health sector and in particular the maternal healthcare services, this court is ... reluctant to determine the questions raised in this petition. The Executive has the political and legal responsibility to determine, formulate and implement polices of Government.... This court has no power to determine or enforce its jurisdiction on matters that require analysis of the health sector government policies, make a review of some of the provisions of these policies and on their implementation* (Uganda Constitutional Court, 2012:14-15).

In other words, the court assumed no role in analysing government policies or reviewing how these policies are put into practice. The court argued that judging on the issues raised in the petition implied taking over the role of the government executive and that the injustice was not a constitutional, but a political issue. The petitioners appealed this decision in the Supreme Court, which struck down the earlier decision by the Constitutional Court. In the ruling, the Supreme Court argued that under the constitution, any person who alleges that an act or omission of an authority is inconsistent with the constitution has a right to file a petition with the Constitutional Court to seek redress (CEHURD, 2018). Unfortunately, while the Supreme Court case created jurisprudence on this matter, its contribution has been mostly of a procedural mediator in nature rather than beneficial to the substantive advancement of the right to health.

Before this case, a few other cases made arguments related to the right to health, but without explicit mention of the right. One case sought and succeeded to declare female genital mutilation as a violation of women's rights, the right to life and freedom from torture (CEHURD, 2018). To facilitate comparison, there were cases on patients detained in hospitals for being unable to pay their medical fees in both Kenya and Uganda.

In Kenya, in *Maimuna Awour and Another v The Attorney General and Others*, the petitioners were detained in deplorable conditions until their spouses and families could raise enough money to pay for their fees. The case touched upon unlawful detention, the right to health, dignity, liberty and freedom from cruel, inhumane and degrading treatment. The court was influenced by the Committee on Economic, Social and Cultural Rights (CESCR) to conclude that state parties must ensure that health services be available, accessible, acceptable and of good quality and that accessibility is harmed by prohibitive costs that render the health services inaccessible. Similar violations arose in Uganda in a case of a patient detained by the International Hospital Kampala for being unable to pay his medical fees. This case, however, was settled through mediation and not heard in court, making the Uganda court's position unclear.

The cases indicate that contractual obligations in healthcare settings still have to be subjected to human rights obligations. Issues such as detaining patients over fee payments have to be examined through a human rights and rule of law lens, as they violate the rights of patients and potentially cause harm to others such as a newborn's postnatal health.

Across both countries, they demonstrate how interpretation of what is a rights violation varies, including across different judges. The right to health in the Bill of Rights, as in Kenya, seems to contribute to increased jurisprudence and realisation of the right. In Uganda, in contract, the jurisprudence is more limited and the case law suggests a lack of understanding of the human rights doctrine by judges and lawyers.

5.3 Popular constitutionalism of the right to health in Kenya and Uganda

Popular constitutionalism can take place in both formal and informal processes where CSOs, social movements, health worker unions, private actors and the media hold the government accountable in fulfilling its duties.

In Kenya, following evidence of the challenges of decentralisation, KELIN developed resources to support civil society to monitor implementation of the right to health under the 2010 Constitution (KELIN, 2016). Civil society groups in Kenya and Uganda have used shadow reporting to submit reports to the United Nations treaty body committee to highlight issues relative to health rights, including those not raised by governments or where they differ from the evidence presented by government.

Both countries have experienced strikes by health workers, especially doctors, over poor conditions and services. In Uganda, medical workers went off duty for two weeks in 2017 over poor working conditions and a lack of supplies for their patients. This action led to eventual acceptance by government to improve their welfare and medical supplies in health facilities. These strikes were partly framed under clause XX of the Constitution, under which the state is required to take practical measures to ensure the provision of basic medical services to the population. Other actions in Uganda explicitly focused on health rights. The Pads4Girls campaign was launched following failure of the president to keep his election promise to ensure free access to sanitary pads for girls. Under this campaign, the activists aimed to collect 10 million pads within a year to distribute to schoolgirls and used this action to remind the state of its constitutional obligations to the welfare of women, including the facilities and opportunities for this.

Some campaigns have been more political in nature. Government opposition leaders in Uganda led a walk-to-work campaign to express concern about people's discontent with worsening socioeconomic conditions, such as increasing fuel, food and transportation prices and poor social service delivery. Article 29 of the Constitution, which makes provisions for the freedom to assemble and to demonstrate together with others peacefully and unarmed and to petition, grounded this campaign. In this case, a perception that the campaign was linked to partisan politics led to suppression and detention of those involved (CEHURD, 2018).

The evidence suggests that explicit inclusion of the right to health and healthcare, as in Kenya, and its implicit inclusion as an objective in Uganda, can enable social advocacy for this right. There are emergent practices around this, although still limited, and indications that it is important to think through the strategies for this and how they are perceived to ensure their sustainability and positive outcome.

6. CHALLENGES IN AND OPTIONS FOR IMPLEMENTING HEALTH RIGHTS

The experiences reported in this paper of how Kenya and Uganda implement constitutional rights to health and healthcare point to challenges that need to be addressed. This section discusses these and how they may be addressed. While it focuses specifically on Kenya and Uganda, the experiences may be relevant for other countries.

Ensuring legal provisions on accountability: The absence of adequate legal provisions defining mechanisms for and ensuring accountability on health rights appears from the evidence in Section 5 to enable laxity of duty bearers and potentially abuse of office of duty bearers. Lack of clarity on procedures for accountability in the health sector deters people from claiming their rights. It is also the case that duty bearers may not understand their obligations, and people may not know or understand their entitlements. The Ugandan Constitution, for example, has a provision for citizens to demand for services because they pay taxes to the state. However, after paying taxes, citizens remain powerless (CEHURD, 2017).

Complementarity of statutes is one means of providing for accountability for the right to health (CEHURD, 2018). Additionally, the regional workshop on advancing the right to health raised the 'OPERA framework' as a further approach. OPERA is an acronym for four components of analysis: outcomes, policy efforts, resources and assessment. This framework can be used to monitor the extent to which governments are protecting, fulfilling and respecting social and economic rights.

In relation to health rights, the analysis starts from outcomes to assess the health situation, which is a realisation of the right to health. The component on policy analyses governments' commitments to these outcomes. Analysis is then done of whether and to what level the state has committed adequate resources to implement these policy commitments. Finally, there is an assessment of constraints that may have deterred government from meeting its obligations (CEHURD, 2017).

Empowering communities: While the policies in both countries make provision for public participation in health, those communities most affected by deprivation of their health rights also lack the capacity and tools to hold duty bearers accountable. CSOs often act on behalf of these communities to seek accountability. It appears from the experiences described in this paper that forces for implementation of health rights are strongest when grassroots citizen networks and groups unite around their health demands and work together to protect their right to health.

It is suggested that more attention be given to the role of and approaches that can be used by CSOs to inform and support community members to seek accountability from duty bearers in the health sector. Health committees have provided one such space capacitating and mobilising community level actors for advocacy and accountability, as a more formal mechanism for dialogue with health workers and the state (Mulumba et al, 2018).

While there has been some attention to CSOs' advocacy and monitoring of heatlhcare, to advance the right to health it would be important for CSO advocacy as coalitions to address the underlying determinants of health, such as shelter, water, sanitation, energy, food security and various forms of pollution, amongst others (CEHURD, 2017).

Addressing the challenges of decentralisation and health financing:
Both Kenya and Uganda included in their constitutions provision for decentralisation of health services. However, adequate resources and capacities have not accompanied decentralisation of healthcare. In both countries, the health sector is inadequately resourced, with Kenya spending only 4% and Uganda 7.8% of their national budget on health. This is well below the 15% committed to by these countries in the Abuja commitment (AU, 2001). .

Currently discussions are underway in both countries, and various mechanisms are being considered and applied to improve revenue flows and to ensure equitable and effective allocation to facilities and services, especially those that best support equity and primary-care services (CEHURD, 2018). While some options may provide improved approaches to health financing, their effectiveness and efficiency should be continually tested in pilot approaches and evaluations. These evaluations would not only generate evidence of benefit and value for money and provide lessons for future scaling up, but also for how far they deliver on progressive realisation of state duties to healthcare and democratise planning and monitoring health financing at lower levels (CEHURD, 2017; 2018). Existing policy frameworks in both countries promoted public participation in health; CSO processes that strengthen health literacy in communities and build community capacity to engage in budget processes at local and national levels can help to strengthen accountability on health financing (KELIN, 2018).

Providing unified guidelines to support multisectoral approaches

The evidence in this paper points to the policy promotion in both countries of multisectoral approaches to health but also to the absence of supporting guidelines for public officials and stakeholder engagements to implement this in practice. It is suggested that such guidelines, applied not only for state sectors and CSOs but also for judicial officers in judging application of how a range of sectors deliver on health rights, would be of value. Many countries are now developing approaches to 'Health in all Policies' that may assist in this, and the Uganda case study reports how the adoption of international guidelines for Health Equity Programmes of Action developed by an international committee led by the O'Neill Institute could further support the integration of rights- based approaches in multisectoral responses (CEHURD, 2018).

This paper highlights how different historical trajectories have led to constitutional inclusion of the right to health in the two countries, explicitly in Kenya in the Bill of Rights and implicitly in Uganda in the objectives. It would be expected that explicit provision of the right to health in the Bill of Rights would make its implementation more likely, but this is not always apparent from the evidence led in Kenya, with various barriers raised to political, judicial and popular forces for implementation. The implicit provision in Uganda and proxy provisions such as the right to life provide opportunities to be invoked to realise the right to health.

Our findings suggest that a positive realisation is more visible in a judicial form of implementation, where judges and lawyers use both national and international doctrines on rights, especially in Kenya where the constitution provides for domestic application of such international norms. In Uganda, while there is evidence of limited progress, the legal ambiguity and a more limited understanding of the human rights approach amongst judges may have led to a variation across judicial officers in the interpretation of rights violations and challenges in litigating on human rights.

In both countries, we found challenges in implementation of policies that affect the implementation of rights, including the weaknesses in accountability mechanisms, in decentralisation and resourcing of services and in people's social power to ensure rights on paper are implemented in practice. This is even more pronounced where rights are contested, as in the case of abortion services, where even constitutional provisions are not enough to advance such reproductive rights in the face of different forces, power interests and political dynamics facing health workers, communities and ministries of health who have a role in their implementation. This increases the focus on popular mechanisms for implementation of health rights. Here too, while constitutional provisions have enabled and motivated social activism on the right to health, as found in Uganda, these processes need to be strategic and consider wider political perceptions and dynamics to avoid negative responses and even the violation of other rights by law enforcers.

Notwithstanding these challenges, the paper points to the value of inclusion of the right to health and healthcare in constitutions, whether implicitly or explicitly, and to the need for continuing processes of and regional exchange on learning from the political, judicial and popular forms of their implementation.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ACHPR	African Charter on Human and People's Rights
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CEHURD	Centre for Health Human Rights Development
CRC	Convention on the Rights of the Child
CSO	Civil Society Organizations
EAC	East African Community
EQUINET	Regional Network on Health Equity in East and Southern Africa
GFF	Global Financing Facility
GoU	Government of Uganda
ICESCR	International Covenant on Economic, Social and Cultural Rights
KELIN	Kenya Legal and Ethical Issues Network on HIV and AIDS
UNICEF	United Nations Children's Emergency Fund
WHO	World Health Organization

Equity in health *implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.*

EQUINET implements work in a number of areas identified as central to health equity in east and southern Africa

- Protecting health in economic and trade policy
- Building universal, primary health care oriented health systems
- Equitable, health systems strengthening responses to HIV and AIDS
- Fair Financing of health systems
- Valuing and retaining health workers
- Organising participatory, people centred health systems
- Promoting public health law and health rights
- Social empowerment and action for health
- Monitoring progress through country and regional equity watches

EQUINET is governed by a steering committee involving institutions and individuals co-ordinating theme, country or process work in EQUINET from the following institutions: TARSC, Zimbabwe; CWGH, Zimbabwe; University of Cape Town, South Africa; CEHURD, Uganda; University of Limpopo, South Africa; SEATINI, Zimbabwe; REACH Trust Malawi; Ifakara Health Institute, Tanzania; Malawi Health Equity Network, University of Zambia; SATUCC and NEAPACOH

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