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Advancing human rights in patient care through strategic litigation: The case of Uganda

By

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DECLARATION

I, **Aruho Amon**, state that this work is a product of my own effort and hereby submitted for the very first time for the above award.

Sign: [redacted]

Dated this 30th day of August 2022

DEDICATION

This research project is dedicated to my late Dad Kategaya Nathan, My Mother Mrs. Rosettie Kategaya, and my Siblings Giffy, Peace, Capt. Nicholas, Benton, Allen, Ham and Peterson whose continuous prayers, support and love have made me reach this goal.

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CHAPTER ONE

GENERAL INTRODUCTION

1.1 Introduction

Observance of human rights forms the bedrock of civilization in society. In most cases, however, the custodians of such rights either act with impunity or do not act at all in the event of abuse of human rights. Internationally, there is a growing reliance on the courts to intervene when those empowered to act fail or refuse to do so.[1] Uganda's Constitution provides for a plethora of rights and their enforcement through different mechanisms.[2] The government, civil society organizations, pressure groups, researchers, medical and legal practitioners are often divided on different aspects, with health care rights being one of them. In this study, the researcher will look at how strategic litigation can be a solution to violation of patients' rights and with specific emphasis on patient detention by health care providers in Uganda.

1.2 Background

Globally, there has been an increase in strategic litigation aimed at enforcing through the courts, the right to health, generally.[3]Strategic litigation means the use of legal action in a sensitive way, mainly aimed at addressing extensive rights' violations.[4] It generally implies litigation with a projected impact away from an isolated case to bring about a wider legal and policy change.[5] Suffice to note, the objective of strategic litigation is constantly to produce a result that go further towards enhancing collective group rights.

Clearly, therefore, the idea of patient's rights may be examined closely by interpreting the respective human rights principles applicable thereto, and predominantly to relations among

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1 Alicia Ely Yamin and Siri Gloppen, eds., *Litigating Health Rights: Can Courts Bring More Justice to Health?* (Cambridge: Harvard University Press, 2011).

2 The Constitution of the Republic of Uganda, 1995.

3 Carole Cooper, "Health Rights Litigation: Cautious Constitutionalism," in *Litigating Health Rights:Can Courts Bring More Justice to Health, eds.* Alicia ElyYamin and Siri Gloppen (Cambridge: Harvard University Press, 2011), 190.

4 Susie Talbot, "Advancing Human Rights in Patient Care through Strategic Litigation: Challenging Medical Confidentiality Issues in countries in transition*" Health and Human Rights Journal*, 2013 at page 70.

5 Amnesty International, "Strategic Litigation," http://www.amnesty.org/en/strategic-litigation/(Accessed February 14, 2020).

seekers of treatment and physicians.[6] The right to patient care, is therefore, something that we need to examine closely especially in light of Uganda's national development goals.

Litigation should be seen as an independent and distinct procedure to enforce the rights of patients. Jurisprudence demonstrates that justiciable rights are more easily enforced by the courts than non-justiciable rights. Although there is no general consensus on the clear meaning of justiciability, some jurists have defined it to mean the possibility of being able to enforce a cause of action especially those relating to violation of fundamental rights.[7] Simply put, it means the decision to run to court for a remedy once one has been wronged.

In jurisdictions where the right to health is expressly spelt out, courts have found the right justiciable, and the Judges have often applied the reasonableness test.[8] For instance, the Indian High Court determined that government has a role of providing health care services to all its citizens.[9] This court made a progressive decision which impacted on health policy in India. Similarly, the Kenyan court decision in *Patricia Asero Ochieng and 2 Others v Attorney General and Another*[10] found the repressive anti-counterfeit law unconstitutional as a result of deviating from the mandatory obligations of government in the Constitution to provide health care to all citizens. Furthermore, in South Africa it was decided, *inter alia*, that it was unconstitutional and unrealistic for government not to provide essential drugs to its citizens.[11]The simple view expressed by this court's decision is that the government is under obligation to deliberately safeguard citizen's rights guaranteed in the Constitution, and for this particular case, extending the availability of Nevirapine to hospitals and clinics in South Africa.

The cases reviewed above show that, with respect to justiciable rights, the courts in those countries were in a position to adjudge claims based on the respective constitutional provisions. It is trite that in Uganda's Constitution, health rights are not enforceable, henceforth, judges often find it an uphill task to hold government to account. This problematic situation reveals that litigation is reliant on the nature of governance in any given country.

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6 Jonathan Cohen and Tamar Ezer, "Human rights in patient care: A theoretical and practical framework, "*Health and Human Rights Journal*. Published December 2013, http://www.hhrjournal.org/2013/12/human-rights-in-patient-care-a-theoretical-and-practical-framework/(Accessed December 15, 2019).

7 International Commission of Jurists, " Courts and the Legal Enforcement of Economic, Social and Cultural Rights," *Human Rights and Rule of Law Series* 2, Geneva (2008).

8 See *Soobramoney v Minister of Health, KwaZulu-Natal*, 1998 (1) SA 765 (CC).

9 *Laxmi Mandal v Deen Dayal Harinagar Hospital & Others* W.P. (C) No.8853/2008.

10 Petition No.409 of 2009.

11 *Minister of Health and Others v Treatment Action Campaign and Others* (No.2) 2002 (5) SA 721 (CC).

Whereas litigation is one of the options for enforcing rights' violations, other avenues like administrative interventions seem not to offer any effective solutions.

The Indian Constitution, like the Ugandan Constitution has Objectives (NODSPs). However, Indian courts have gone further to harmonize their NODSPs and fundamental rights guaranteed in the Constitution, thereby finding those rights justiciable and enforceable.[12] This is a sharp contrast with countries like Uganda where the National objectives are still generally considered unenforceable. However, like the Indian court did in the Kerala case, legal action is an important medium of protecting patients' rights to receive treatment and prohibit physicians from detaining patients who have failed to pay medical bills. In Uganda, the bill of rights contains various rights which when read together can inform Judges and other rights champions on how best to realize enforcement of such rights.

Legal scholars like Mbazira have argued that Article 8A of The Constitution (Amendment) Act, 2005 gives legal effect to the National Objectives.[13] It could, therefore, be possible to oblige the state to perform its duty relating to implementation of health rights through litigation.

Therefore, exploring litigation using the human rights discourse, rights advocates' highlight the suffering of individuals in order to tackle universal inequity and instigate government to commend to positive policy change. However, for full realization of health rights, there is need for a pro-active judiciary, it is possible for Judges to interpret and find justiciable non-justiciable rights in the Constitution.

Over the years there have been attempts by rights activists in Uganda to dare the courts to interpret and enforce health rights, which are generally not considered justiciable. In *CEHURD & Others v Attorney General*,[14]government was dragged to Court for, *inter alia*, failure to provide birthing kits in Government health facilities was in contravention of the Constitution. The Respondent opposed the petition on grounds that the court had no powers to hear the petition since it called upon the court to make findings on the state's health policies, which were a preserve of the Executive arm of government. Indeed, the Court concurred with

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12 *Kesavananda Bharati v State of Kerala (1973) 4 SCC 225*. Find at http://indiankanoon.org/doc/257876 (Accessed on 18th November, 2020)

13 Christopher Mbazira, "Public Interest Litigation and Judicial Activism in Uganda: Improving the Enforcement of Economic and Social Rights," *HURIPEC Working Paper* Issue 24, Faculty of Law, Makerere University, 2009.

14 Constitutional Petition No. 16 of 2011.

the Respondent on the technicality and dismissed the petition. It is clear that Court relied on the *political question doctrine* to decide as it did without hearing merits of the case.

The idea of the political question principle was, perhaps, best articulated in the dictum by Chief Justice John Marhsall of the United States, when he observed as follows:

> "The province of the court is, solely, to decide on the rights of individuals, not to enquire how the executive, or executive officers, perform duties in which they have a discretion. Questions, in their nature political, or which are, by the constitution and laws, submitted to the executive, can never be made in this court."[15]

Therefore, the political question conceives the judiciary as a vital arm of government but which should not descend into ruling on policies of the Executive. Being unhappy with court's decision, CEHURD appealed to Supreme Court which unanimously allowed the appeal, and directed the Constitutional court to re-hear the petition. In that appeal, Chief Justice Bart Magunda Katureebe observed, thus:

> "With great respect to the Constitutional Court, I think they misunderstood what was required of the court. I do not think the court was required to determine, formulate or implement the health policies of government. In my view, the court is required to determine whether the government has provided or taken all practical measures to ensure the basic medical services to the population. In this case it is maternal services in issue."[16]

In this regard, the independence of the lower court was put in doubt in so far as the court failed to review jurisprudence from other jurisdictions such as; decisions in *Minister of Health & others v Treatment Action Campaign and others*,[17] and *Paschim* case,[18] where Courts emphatically found their governments accountable.

On 19th August, 2020 Constitutional Petition No.16 of 2011 was finally determined in favour of the Petitioners. The Court affirmed obligations of Government to provide health care and

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15 See *William Marbury v James Madison* (1803) Supreme Court of the United States (Available at https://www.law.cornell.edu/supremecourt/text/5/137 (Accessed on 30th November,2020).

16 *The Center for Health, Human Rights and Development & 3 Others v Attorney General*, Constitutional Appeal No. 1/2013. Retrieved at https://ulii.org/ug/judgment/supreme-court- uganda/20122/4-0 (Accessed on 30th November, 2020).

17 *Ibid.*,note 11.

18 *Paschim Banga Khet Mazdoor Samity v State of West Bengal* (1996) 4 SCC 37.

medical services in Uganda. The Court made further orders to the Attorney General to submit a report at the end of 2020/21 Financial Year on progress with implementation of the orders.

Indeed, the successes registered in the Nanteza case and Petition No.16 of 2011 demonstrate positive efforts towards compelling Government to honour its Constitutional duty of ensuring accessibility of health services to its population. Strategic litigation employed here contributed significantly to raising awareness in the community about the Constitutional and Institutional duty of the state as aforementioned.

The above decisions of court also brought support and motivation for CEHURD and other rights champions to intensify strategic litigation based on human rights principles to argue that incarceration of individuals by providers for accrued medical bills is illegal.

In another *locus classicus* case of *CEHURD v Nakaseke District Local Government*,[19] the Plaintiffs brought the suit in the interest of the deceased victim who had sought medical attention at Nakaseke hospital. The issues, *inter alia*, were whether failure by the hospital to provide timely obstetric care to the deceased violated her constitutional rights. In its obiter, the court wondered why the doctor and the hospital administrators were not made parties to the case. The realities in Uganda of high maternal mortality point to the fact that the citizens should not tire from demanding accountability from the government to invest in the health sector.

The above progressive court decisions have been significant in enlightening the public about the negative performance of the health sector in the country.[20] For instance, the Nakaseke case demonstrated the plight of expectant mothers at the hands of government hospitals and exposed the negligence at such facilities. By court expanding the scope of negligence in medical malpractice, it instilled hope in citizens that errant doctors and other physicians can be held accountable for their misdeeds.

In the above instances, CEHURD took up the cases on behalf of the victims and their families through its strategic litigation program so as to advocate for the aforementioned rights on behalf of a bigger population, other than bringing a personal action in negligence against the individual doctor.

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[19] *The Center for Health, Human Rights and Development and 4 Others v Nakaseke District Local Administration*, Civil Suit No.111 of 2012, available at https://www.escr-net.org/node/366203 (Accessed on 30th November,2020).

[20] Sarah Rudrum, "*Landmark Decision in Uganda in Case of Maternal Death is a Cause for Celebration*."Sexual and Reproductive Health Matters, 18th May, 2015, available at https://www.srhm.org/news/landmark-decision-in-uganda-in-case-of-maternity-death-.

As far as the widespread practice of patient detentions for failure to pay medical bills is concerned, in 2016, CEHURD and Rose Obigah sued International Medical Group , arguing that the detention of Patrick Obigah (the 2nd Plaintiff's husband) by the administration of the International Hospital Kampala (IHK) until he cleared the outstanding balance of the medical bills which was Ugx. 19,514, 425/= (Nineteen Million Five Hundred and Fourteen Thousand Four Hundred and Twenty Five Shillings) was illegal and unconstitutional.

Although this case is still pending, it demonstrates that strategic litigation can further be employed as an effective tool in exposing the uncouth and unprofessional practice of patient detentions by physicians for failure to pay their medical bills. Several other incidents of this nature continue to occur in different public and private health centers all over the country and are usually brought to the attention of the public through the media.

Over the last decade, there has been consistent practice of illegal patient detentions by hospitals, a common practice predominantly among private health centers, in Uganda.[21] In this thesis, the researcher explores the legality and morality of patient detentions by reflecting upon the current state of this practice in Uganda.

The above discourse testifies to the deteriorating nature of the rule of law manifested by persistent breach of patient's rights by providers. In light of these challenges, health activists have successfully advocated for recognition of health rights.[22]

1.3 Statement of the Problem

The practice of patient detentions for accrued medical bills at the time of discharge with the hope that their family and friends will bail them out has been rapidly growing. Despite the hopes that these sort of practices would have been eradicated by now, a lack of effective measures for civil redress and financial assistance from government have left Ugandan physicians choosing to violate one set of human entitlement in a bid to provide another.

Recalling the country's challenging history characterized by rights' violations, framers of the Constitution thought wise to include certain deliberate safeguards. These point to the

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21 Micheal Otremba (2002). When Doctors Become Creditors: The Detainment of Impoverished Patients in Uganda. A thesis submitted to Yale University. Available at *https://elischolar.library.yale.edu/cgi/viewcontent.cgi?article=1750...ymtdl* (Accessed on 15th January, 2021).

22 *Ibid.*,note 14 and 19.

obligation of the rulers/leaders over the ruled/citizens. As can be discerned from principle XX of NODSP, which states:

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

However, despite the good motive of the above provision, justiciability of the NODSP in the Constitution of Uganda continues to be contested. It should be recalled further that the Constitution guarantees the protection of personal liberty, in the sense that detention of any individual arrested should be in a gazetted and authorized facility.[23] In addition, the Constitution outlaws slavery by emphasizing tolerance of one another and forbidding any form of mistreatment.[24]

However, despite all these clear provisions in the Constitution, the practice of continued patient detentions by health facilities for failure to pay medical bills is on the increase and this is because of the perception most patients have that these health facilities have a right to hold them captive in such desperate situations.

In the same vein, various international treaties stipulate procedures to be undertaken by member states with help from development partners with a view of progressively achieving the right to health care which among others entails respect of patient's rights. However, Uganda being a dualist country, it emphasizes the distinction between internal and external law and requires domestication of international law into domestic law. Without this translation, international law has no effect in Uganda. Therefore despite ratification of these international instruments by Uganda, they have not been domesticated and hence they remain only persuasive.

Furthermore, in the Kenyan case of *Gideon Kilundo v Nairobi Women Hospital*,[25]it was held that it is illegal to hold patients as a result of accrued medical bills. Lady Justice Okwany stated that holding a patient should not be one of the avenues to be used to recover debts as it amounts to denial of freedom of movement, however, the court dismissed the plaintiffs' claim for compensation for the days the plaintiff had been detained.

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[23] *Ibid.*, note 2, Art. 23.
[24] *Ibid.*, Art. 24.
[25] *Gideon Kilundo and Daniel Kilundo Mwenga v The Nairobi Women's Hospital* (Petition No. 242 of 2018), accessed on 11th January, 2021 at http://kenyalaw.org/caselaw/cases/view/158915/.

In Uganda, however, it would appear that a vast majority of the population being impoverished is desperate for medical services and this partly explains why such people rarely explore legal remedies when their rights are infringed. For instance, Wesaka, in his article published in the Monitor Newspaper suggests that the holding of patients for non-payment of treatment costs is so widespread that it is often wrongly believed that hospitals have the inherent right to detain patients.[26]On the other hand, Mr. Muwema is of the view that the practice of detaining patients by hospitals is not only immoral but criminal.[27] This is the position under Section 248 and 121 of the Penal Code Act,[28]which establishes criminal offences for unlawfully detaining a person and a dead body respectively.

There have been numerous efforts by different rights' activists highlighting the glaring evidence of the violation of patient's rights by public and private hospitals/health centers. For example, a patient (Patrick Obiga) who was due for discharge was detained by the International Hospital Kampala (IHK) for failure to pay Ug.Shs 19.5 million as treatment arrears.[29] In the same vein, another renowned private hospital in Kampala, Nsambya Hospital detained a fish monger, for failure to pay his accrued bills of Ug.shs 4.3m.[30] These are some of the many cases of patient detentions by hospitals in Uganda for failure to pay medical bills.

Amidst all these challenges, legal action is rarely taken, implying that the perpetrators of such patients' rights violations are not held to account. However, over time, strategic litigation has been intensified and government is being held accountable. In the Nakaseke case where CEHURD filed a suit in respect of an expectant mother who passed on while giving birth at Nakaseke hospital as a result of the negligence of the doctor and other attendants on duty, and the Local government was held accountable for the inactions of the doctor on duty which resulted into the death of the patient. On 17th July 2019, Justice Lydia Mugambe in *Initiative for Social and Economic Rights (ISER) v Attorney General*,[31]decided that the selective policy

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[26] Anthony Wesaka, "It is illegal for hospitals to detain patients over bills, *"The Daily Monitor*, Published Tuesday November 22, 2016 (Accessed at https://www.monitor.co.ug on 11th August, 2019).

[27] Fred Muwema, "It is criminal for hospitals to detain patients over unpaid medical bills," *The Daily Monitor*, Published Wednesday 7th July, 2021 (Accessed at https://www.monitor.co.ug on 22nd September, 2021).

[28] Cap 120, Laws of Uganda.

[29] *Ibid.*

[30] The Daily Monitor Newspaper, "Hospital detains patient over Uganda Shillings 4.3m debt," (Accessed at https://www.monitor.co.ug) (Accessed on 16thAugust, 2019) at 0016 hours.

[31] *Initiative for Social and Economic Rights (ISER) v Attorney General* (Civil Suit 353 of 2016).

of the government on public financing of secondary education was unconstitutional for infringing on right to equality and education.[32]

Consequently, this research will demonstrate that strategic litigation is a critical instrument to use, since through courts, the government can be ordered to take measurable processes for the progressive recognition of these rights as was in the Nakaseke case and Petition No.16 of 2011. Strategic litigation will help courts to interpret the Constitution holistically, and in the process direct the government to comply, even when these rights are generally not justiciable.

1.4Objectives of the study

1.4.1 General objective of the study

The general objective of this research project is to argue for the need to progress human rights in patient care through strategic litigation taking the case study of Uganda.

1.4.2 Specific objectives of the Study

There are four specific objectives of the study:

- **a)** To provide an overview of the human rights framework protecting patients in Uganda;
- **b)** To examine the recourse available to patients whose rights have been violated;
- **c)** To assess the impact of strategic litigation in Uganda or other jurisdictions in relation to patient detention; and
- **d)** To recommend possible reforms to policy makers and other stakeholders.

1.5 Research Questions

Can strategic litigation assist where the rights in question are not justiciable?

1.6 Significance of the Study

Through strategic litigation cases such as those challenging the illegal holding of patients by physicians for accrued treatment bills, the right to patient care will be more fully realized in Uganda, as Government will be compelled to effect policy changes. Further, this study will show that the human rights angle is capable of being used to address violation of patients' rights and to bring awareness about holding the state accountable where it is necessary as was the case in the aforementioned examples.

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[32] *ibid* note 2., Article 30 thereof makes the right to education justiciable unlike the right to health which is not. Nevertheless the decision has far reaching implications on government policy in the education sector but it also acts as an impetus for review of other government health policies.

1.7 Methodology

This is a desktop research based on government policy documents in the public domain, reports, media articles and recent peer reviewed publications, and books.

1.8 Literature Review

Issues of strategic litigation and its impact on patient care have drawn a lot of attention world over.[33] However, literature on this issue as it affects Uganda is not as extensive and in depth as it should be. Nevertheless, we cannot overlook the fact that the rights of patients are always at a risk in such cases. In Uganda, a majority of the population cannot afford the basic costs of services at private health facilities and at a few public health facilities with cost sharing.[34] This leaves many poor patients at the mercy of physicians who often detain them for failure to pay medicals bills for services rendered.

The National Health Insurance law has been debated in Parliament of Uganda but is yet to be passed into law[35], implying that currently only 3% of the population of Uganda has health insurance.[36] The preamble to the bill states its objectives, thus:

> "The bill is intended to facilitate the provision of accessible, affordable acceptable and quality healthcare services to citizens irrespective of their age, economic, health and social status."

Thus, currently the majority of Ugandans have to foot their own medical bills, which is always higher than is expected. Principle IV (b) of the National Objectives in the Constitution bestows task on the state to realize the fundamental entitlements of citizens which includes patient's rights. This provision has, however, not been effectively enforced due to the non-binding nature of health rights in Uganda.

However, Kenyan courts have ruled that holding a patient for non-payment of medical bills goes against the conventional rules for recovering debts in so far as it violates the patient's constitutional privileges to personal freedom and protection of the liberty to move.[37]The Court

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33 See Studies by; Talbot, "Advancing Human Rights in Patient Care Through Strategic Litigation,", Otremba, "When Doctors become Creditors," (2002) and Christopher Mbazira, "Public Interest Litigation and Judicial Activism in Uganda: Improving the Enforcement of Economic and Social Rights."

34 Rosebell Kagumire, "Public health insurance in Uganda still only a dream*,"Canadian Medical Association Journal*180, Issue No.3 (2009). Accessed at https://www.ncbi nlm nih.gov/pmc/articles/PMC2630345/ on 18th August, 2019.

35 The National Health Insurance Scheme Bill of 2014, Uganda. (Accessed on 18th September, 2019 at https://cepa.or.ug/.../282999548-Unpacking-the-National-Health-Insurance-Bill-2...).

36 Kagumire, "Public Health Insurance in Uganda still only a dream".

stressed further that in such situations, two competing rights have to be balanced; the right to personal freedom and the right to property but should be resolved in favour of the patient.

Given the continuing nature of patient detentions, it is challenging to verify accurate statistics relating to the actual number of people detained since most of these incidents go unreported and even those isolated cases that are eventually exposed especially through the mainstream and social media are rarely followed to their logical conclusion. It is likely that this predicament is yet more prevalent than established in research. Like some scholars have suggested, patient detention is not a new phenomenon in Uganda but occurs across much of sub -Saharan Africa.[38]

It is, therefore, legally possible to challenge the practice of patient detentions through strategic litigation by highlighting other auxiliary rights. For instance; the constitutional entitlements to liberty and freedom of movement under Articles 23 and 29(2) of the Constitution respectively, which are violated if a physician detains his/her patients. Through strategic litigation, Ugandan courts can be moved to read the Constitution holistically and enforce health rights, even though the same is generally considered non-justiciable. As the courts do this, they are expected to draw lessons from similar cases decided in other countries like Kenya, India and South Africa.

1.9 Chapter Synopsis

Chapter one presents the introduction, background to the study, statement of the problem, objectives of the study (general and specific), research questions, significance of the study, scope of the study, literature review and methodology.

Chapter two examines the human rights framework on patients' rights in Uganda. This chapter will explore the national, regional and international dimensions governing/ protecting patients' rights.

Chapter three examines the recourse available to patients whose rights have been violated, among which are; administrative, tribunals, disciplinary action and Court.

Chapter four assesses the impact of strategic litigation in Uganda and other jurisdictions in relation to patients' detention in Uganda.

Chapter five provides the conclusion and recommendations for the study.

[38] Robert, Y., Tom, B., & Eloise, W. (2017). *Hospital Detentions for Non-payment of Fees: A Denial of Rights and Dignity*. Centre on Global Health Security.

CHAPTER TWO

THE HUMAN RIGHTS FRAMEWORK PROTECTING THE RIGHTS OF PATIENTS IN UGANDA

2.1 Introduction

In the preceding chapter, it was demonstrated that there is a recurring problem of hospitals holding patients captive for failure to pay treatment arrears in Uganda and has pointed out that this practice infringes on patient's rights, even though this right is unenforceable in the Constitution. Nevertheless, the study has pointed out that strategic litigation will be the best option in the circumstances to compel government to undertake its obligations and enforce health rights more effectively. Against this backdrop, this chapter seeks to discuss the relevant frameworks protecting the rights of patients locally and externally.

2.2 Domestic Context

The rights to patient care, like all human rights impose the responsibility on government to value, defend and realize that right. In the discussion below, I will examine Uganda's Constitution, policies and guidelines through which the rights of patients are protected.

2.2.1 The Constitution of Uganda

The right to health is not generally justiciable in Uganda. However, government is enjoined to protect this right as part of its mandate expressly stated in the Constitution's section of the National Objectives and Directive Principles of State Policy (NODPSP). Objective 14(b) states, thus:

> "The State shall endeavor to fulfill the fundamental rights of all Ugandans to social justice and economic development and shall, in particular, ensure that –
> **(b)**all Ugandans enjoy rights and opportunities and access to education, health services, clean and safe water, work, decent shelter, adequate clothing, food security, and pension and retirement benefits."[39]

[39] The Constitution, Objective XIV(b) (1995).

It is clear from the above provision that government has the primary responsibility to make sure that all citizens access health care services whenever needed. Objective XX places additional duties on the State, thus:

> "The State shall take all practical measures to ensure the provision of basic medical services to the population."[40]

It can be argued, therefore, a close interpretation of Objectives IV (b) and XX places additional duties on government to render health services to its citizens without discrimination on financial grounds.

Much as the obligations of government are enshrined in the NODPSP part of the Constitution, sadly, they are not justiciable. Nevertheless, the purpose of the objectives and principles as stated in Objective I (i) of the NODPSP is to act as a guideline to the State, thus:

> The following principles and objectives shall guide all organs and agencies of the State, all citizens, organizations and other bodies and persons in applying or interpreting the Constitution or any other law and in taking and implementing any policy decisions for the promotion of a just, free and democratic society.

The above provision of the NODPSP clearly confirms that the objectives and principles are not intended to be legally binding but only directory. This dreadlock has caused confusion in the legal circles, which could certainly not be remedied by the 2005 amendment of the Constitution introducing a new Article 8A, which provides in clause 1 thereof, thus:

> "Uganda shall be governed based on principles of national interest and common good enshrined in the national objectives and directive principles of state policy."[41]

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40 *Ibid.*,Principle XX.

41 See the Constitution (Amendment) Act, 2005.

In the same spirit, scholars like Mbazira advance the view that the location of the above provision within the Constitution gives legal effect to the Objectives.[42] Thus, whereas the provisions on health rights are not expressly mentioned, an expansive reading of other constitutional provisions and the Directive Principles reinforce the justiciability of Article 8A.[43] It may further be argued that Article 50 thereof can be interpreted to operationalize the provisions guaranteeing health rights. For clarity, Article 50(1) stipulates as follows:

> "Any person who claims that a fundamental or other right or freedom guaranteed under this Constitution has been Infringed or threatened is entitled to apply to a competent Court for redress..."

It is noteworthy that Ugandan judges are interpreting and enforcing rights using the aforementioned constitutional provision as a measure of giving effect to the National Objectives.[44] This implies that despite being non-justiciable, health rights are capable of being enforced just like other justiciable rights where the given judicial officer interprets the constitutional provisions as a whole.

Regarding the practice of patient detentions, the Constitution has several provisions dealing with the issue. Firstly, Article 24 forbids torture or inhuman and degrading treatment, when it states, thus:

> "No person shall be subjected to any form of torture or cruel, inhuman or degrading treatment or punishment."

From the above, it has been argued that the holding of individuals for failure to pay accrued treatment expenses violates the rights of patients to receive treatment without being traumatized with mistreatment.[45] Detention of a patient is a violation of his/her right to liberty guaranteed under Article 23(1) of the Constitution. This is so because hospitals are not *per se* gazetted detention facilities under the Constitution. For instance Article 23(2) of the Constitution which deals with that issue, states, thus:

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42 Mbazira, "Public Interest Litigation and Judicial Activism in Uganda: Improving the Enforcement of Economic and Social Rights."

44 See for instance *CEHURD & Others v AG, Constitutional Petition No.16 of 2011 & Julius .O. & 205,000 Others v AG*, HCCS No.292 of 2010.

45 The Center for Reproductive Rights, "Reproductive Rights Violations as Torture and Cruel, Inhuman, or Degrading Treatment or Punishment: A Critical Human Rights Analysis," Vol.21–24 (2011).

"A person arrested, restricted or detained shall be kept in a place authorized by law."

It follows, therefore, that hospitals violate the rights aforementioned when they detain patients for whatever reason, including non-payment of bills.

Furthermore, the provisions of Article 41 on the right of accessing vital information can be explored further to show that both government and health facilities violate patient's rights when they do not disseminate all information required by a patient prior to admission and/or seeking treatment. However, this excuse can be rebutted by consensual arrangements, especially where a patient opts for a private hospital instead of a public one.

The obligations of government to realize patient's rights can be inferred by reading into other bundle of rights. To this end, Article 22(1) of the Constitution provides as follows:

"**22. Protection of right to life**

(1) No person shall be deprived of life intentionally except in execution of a sentence passed in a fair trial by a court of competent jurisdiction…"

Therefore, since the holding of patients captive can directly and indirectly jeopardize their right to life as was the case in the Nanteza matter and Petition No.16 of 2011,lawyers can advance an argument that by government failing to honour its stipulated obligations, it also indirectly violates other related rights.

Furthermore, other additional rights not directly mentioned in the Constitution can be given legal efficacy. In this regard, **Article 45** thereof, stipulates, thus:

> "The 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."

Therefore, the above Article paves way for interpretation of relevant treaty law in discerning core provisions relating to health rights.

As discussed earlier, **Article 8A clause 2** of the Constitution provides that:

"(2) Parliament shall make relevant laws for purposes of giving full effect to clause (1) of this article."[46]

Clause 1 thereof stipulates that, "*Uganda shall be governed based on the principles of national interest and common good enshrined in the national objectives and directive principles of state policy."* However, it is over a decade and no such law has been enacted. Even the Patient's Rights and Responsibilities Bill, 2019 which is supposed to provide for rights and responsibilities of patients and health workers has been shelved by Parliament to-date.[47] According to clause 1 of the Bill, its general objective is to operationalize objective XX and to further give the Patient's Charter the force of law. It is hoped that a speedy enactment of the Bill into law will provide the requisite human rights framework and mechanism which will spell out the obligations of both health workers and patients.

2.2.2 Law Regulating the Practice and Conduct of Medical Professionals in Uganda

Cognizant of its constitutional mandate, the government of Uganda regulates access to healthcare by health professionals through statute and some operational guidelines issued by the Ministry of Health. Suffice to point out is that, the regulatory framework is intended to curb unprofessional practice, as well as offer appropriate procedures to be taken by an aggrieved patient arising from the conduct and practice of the physician.

As such, a number of laws and guidelines are applicable to the practice and conduct of medical professionals in Uganda. These include; the Medical and Dental Practitioner's Act (MDP Act)[48], the Allied Health Professionals Act (AHP Act)[49], the Nurses and Midwives Act (NMA)[50], the Pharmacy and Drugs Act (PAD Act)[51], and the Patient's Charter, discussed at length in the subsequent section.

Under section 1(m) of the MDP Act of 1998, a practitioner is defined to mean a person registered under section 21 of the Act to practice medicine, surgery or dentistry. Therefore, this Act regulates the conduct and practice of medical as well as dental practitioners. The same Act creates *the Medical and Dental Practitioners Council* (the Council herein) under

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46 *Ibid* note 2., (as amended in 2005), clause 2 of Article 8A thereof.

47 The Patient's Rights and Responsibilities Bill of 2019, retrieved at https://www.parliament.go.ug/ on 30thOctober, 2019 at 10:16 hours.

48 Chapter 272, Laws of Uganda.

49 Chapter 268, Laws of Uganda.

50 Chapter 274, Laws of Uganda.

51 Chapter 280, Laws of Uganda.

sections 2 and 3 to promote and enforce professional medical and dental ethics. Hence, an errant physician who may have abused his client's rights can be disciplined by that council.

Furthermore, under section 29(1) of the MDP Act, the Council is mandated to oversee the registration of private health units where a health professional intends to practice. This role is intended to supplement government's efforts of ensuring that the population receives medical services offered by qualified health experts thereby realizing the citizen's health rights.

Therefore, whereas the Act spells out the qualification, discipline and regulation of medical professionals in Uganda, the Act does not seem to clarify in express terms the relationship between a health professional and his/her rights. Of course, this is without prejudice to the option of lodging a complaint with the relevant disciplinary body. It can therefore be deduced that in their day to day roles, medical professional are obliged to offer services to the population for purely economic gain without considering the social aspect involved.

Under *the Code of Professional Ethics for Medical and Dental Practitioners*,[52] a practitioner is under duty not to deny emergency treatment or health care to a patient.[53]This position is further buttressed by the Patient's Charter under Article 1, which provides as follows:

> "In a medical emergency, a person is entitled to receive emergency medical care unconditionally in any health facility without having to pay any deposits or fees prior to medical care."[54]

However, the Charter is silent on recourse available to a practitioner if no payment is received in respect of medical services rendered. It follows therefore that a practitioner faced with this dilemma may legally be at liberty to enforce payment through a debt recovery process established by a binding contract between him and the patient other than taking the law in his/her hands to detain the patient, as is the *status quo*. Furthermore, the Code requires every practitioner to exercise due diligence and provide service of good quality.[55]This is intended to protect the medical profession as well as the patients.

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52 Hereinafter referred to as the Code.
53 *Ibid*.,Clause 8(1).
54 The Patients Charter, 2009, Article 1 thereof.
55 *Ibid*.,Clause 8(2).

In Uganda, following consistent public outcry about the detention of patients and dead bodies by medical facilities for failure to pay hospital bills, on 16th August 2021, the Uganda Medical and Dental Practitioner's Council (UMDPC) issued a strong statement in which the Council condemned the habit of detaining patients and or dead bodies for failure to clear medical bills.[56]Needless to say, Section 43 of the MDP Act provides that a registered medical or dental practitioner may demand reasonable charges for their services. The same provision grants a right to sue in any competent court to recover any outstanding medical bills.

Under section 2 of the AHP Act, the Allied Health Professionals Council is established as a body to regulate all allied professionals. The specific functions of the Council, including regulating the standards of allied health professionals are stipulated under section 4. Like all other professionals, allied health professionals are subject to disciplinary action by the Allied Health Professionals Council.[57] This is intended to enhance high standards of professional conduct and safety of patients.

Yet another important category of medical professionals are the nurses and midwives. These are middle-level providers of health services and they are regulated by *The Nurses and Midwives Act*,[58] and *the Code of Conduct and Ethics for Nurses and Midwives, 2009*. In the course of their practice, nurses and midwives are prohibited from carrying out procedures beyond normal conditions and are thus required to refer cases beyond them to a medical practitioner.[59] This provision is aimed at protecting patients and a nurse or midwife who violates it may be subjected to disciplinary sanction by the Disciplinary Committee pursuant to section 37 of the Act.

2.3 Policy Framework

The health ministry has developed numerous health policies and guidelines tailored towards the operationalization of state obligations in providing health services to the population. These include; the National Development Plan; the National Health Policy; the Health Sector Strategic and Investment Plan; the National Adolescent Health Policy and Reproductive Health Policy; and the Patient's Charter of 2009.

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56 The Full Statement is Available on http://www.umdpc.com/ (Accessed on 22nd September, 2021).
57 Section 4(h) AHP Act.
58 *Ibid.*
59 *Ibid*., Section 34(2).

Under the National Development Plan (NDP)[60], it is recognized that good health plays a key role in the transformation of people's livelihood and development of the country. At current, Uganda has developed the third NDP (NDPIII) which is from 2020/21 – 2024/25 and its goal is *to increase household incomes and improve quality of life*. NDPIII is part of government's efforts aimed at transforming the country in order to achieve a middle income status. Under section 1.2.1 (xi) NDPIII reports that in the last decade, there have been significant achievements regarding the ability of the population to receive medical services. For instance, the opening of a modernised women's hospital with a capacity of 320 beds in Mulago, and the expansion of the Mulago Cancer Institute. The NDP III further notes that the functionality of health facilities is still low resulting into serious maternal health conditions. It prioritizes development of other sectors like agriculture, tourism, minerals and petroleum development and not health sector.

In furtherance of the NDPs developed by the National Planning Authority (NPA), Ministry of Health has been developing National Health Policies.[61] The first National Health Policy (NHPI) came in 1999, and the second National Health Policy (NHP II) was developed in 2010.The policy recognizes that investing in the support of health of the people tantamount to the realization of rights for the population. Hence, this stance is attributed to the objectives in the Constitution which places the responsibility on government to provide such services to the people. When the population is productive, citizens can contribute productively towards national development.

In September 2015, Ministry of Health came up with the second Health Sector Development Plan (HSDP II) 2015/16 – 2019/20[62]which essentially elaborates on the first Health Sector Development Plan (HSDP I) of 2010/2011 – 2014/2015. HSDP II is general in nature but it mainly focuses on health care investment and realization for both government and individually-owned hospitals in view of the aspirations set out in NDP III.The HSDP II calls upon government to streamline access to health care services in compliance with its national and international obligations.

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60 The National Development Plan, retrieved at http://www npa.go.ug/development-plans/national- development-plan-ndp/ (Accessed on 16th September, 2020)

61 *Ibid.*

62 *Ibid.*

Since majority of Ugandans are young people, government has been streamlining initiatives and programs such as Youth Livelihood Program to enhance youth livelihood. Hence, this contributed to the development of The National Adolescent Health Policy of 2004 (NAHP).[63] This policy seeks the involvement of young people in the social-economic transformation of their country. It thus recognizes that adolescent health is as important as the health of anyone. Therefore, the policy advocates for inclusion of adolescents in government programs in order to improve the standards of life and living among adolescents.

In the previous chapter, I demonstrated that majority of patients are ignorant of their rights hence contributing to the widespread patient detention cases which go unreported. This lacuna was appreciated by the government, prompting it to develop the Patients' Charter of 2009(the Charter herein). The Charter can be seen as a deliberate effort by the state to operationalize its obligations pursuant to objective No. XX of the 1995 Constitution.

The Charter is broadly structured into three sections; the first dealing with patients' rights, second deals with responsibilities of the patient and the last dealing with the responsibilities of health workers. A health worker is defined under the Charter to include not only health professionals but the definition broadly extends to other categories of employees such as the administrative and support staff.

Most importantly, the Charter expressly recognizes the right to medical care. This is stipulated in Section 1 of Article 1, which states as follows:

> "Every person in need of medical care is entitled to impartial access to treatment in accordance with regulations, conditions and arrangements obtaining at any given time in the government health care system.
>
> In an medical emergency, a person is entitled to receive emergency medical care unconditionally in any health facility without having to pay any deposits or fees prior to medical care."

The above article prioritizes the provision of treatment to whoever seeks it. It follows therefore that any person such as the poor seeking treatment especially in emergency situations are at liberty to access health services at any facility, and issues of social status should not be a pre-requisite as most physicians often demand or worse still, as has been the case, detain patients for non-payment of accrued medical bills.

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[63] *Ibid.*

Furthermore, Article 2 Section 1 of the Charter prohibits discrimination of patients in the process of receiving medical services. The provision states, thus:

> "No health facility or health provider shall discriminate between patients on ground of disease, religion…social status…"

Therefore, a closer reading of the above provision may lead one to the conclusion that detaining any person for any reason amounts to discrimination of the patient in view of the Charter.

Article 19 thereof establishes the forum for seeking legal redress by an aggrieved patient arising from violations of the rights contained therein. The provision provides, thus:

> "**19. Right to Redress**
>
> Every health facility shall designate a person or committee to be responsible for the observance of patient's rights…"

The above Article is operationalized by Article 25 of the Charter which provides that any health worker who violates the rights set out in the Charter can be subjected to sanction from "Health Unit Management committees, Health Professional Councils, Medical Boards, and Courts of law."

The codes for health care professionals are incomprehensive since they do not expressly and explicitly address the illegal detention of patients by physicians, which is on the rise. The Patient's Charter, 2009 itself does not provide for express penalties let alone having no binding force of law. The Charter is a mere guideline as is clearly stated in its FOREWORD "the patient charter is meant for use in Uganda but may be used as a reference material by other health and humanitarian organizations. "It is even not easily accessible to the public, hence, most health care providers have, as a result, exploited the current gaps to their advantage by continuing to hold patients *incommunicado* for accrued medical bills.

2.4 International and Regional Framework

A number of instruments are applicable to Uganda regarding the right to health. The most significant of these are: the Universal Declaration of Human Rights (UDHR) of 1948;[64]the International Covenant on Economic, Social and Cultural Rights (ICESCR);[65]the Convention

[64] The Universal Declaration of Human Rights was proclaimed by the General Assembly of the United Nations on 10th December, 1948.

[65] Retrieved at https://www.ohchr.org/ (Accessed on 01st October 2019).

on the Elimination of all Forms of Discrimination against Women (CEDAW);[66] the African Charter on Human and People's Rights (ACHPR);[67]and Treaty for the Establishment of the East African Community (EAC Treaty).

Under Article 25 of the UDHR, everyone is entitled to an adequate standard of living, including patient care. The UDHR demands special care and attention to some groups of people like those marginalized in society. Article 9 of the UDHR prohibits persons from being subjected to arbitrary arrest, and detention. Although the provision does not directly address patient detentions, by implication, a physician is not permitted to hold a patient for accrued medical bills. The UDHR was domesticated and ratified by Uganda, and as such applicable to Uganda.

Similarly, under Article 12(1) of the ICESCRS, it is incumbent upon the state to recognize the right of citizens and non-citizen's to enjoy health care in its physical and mental forms. As the Human Rights Committee has noted in its General Comment No.14, the right to health contains four critical elements; availability, accessibility, acceptability and quality. Therefore, the state as a regulator of the public health system is under obligation to set basic standards for the unconditional access of health services and to hold the violators accountable. The Convention does not directly address patient detentions, which is a prevalent practice in Uganda, and as such we argue that, it is the duty of state institutions like the judiciary to interpret and find that by detaining patients, physicians act unconstitutionally.

In addition, under Article 18 of the CEDAW, the state is called upon to uphold human rights. Article 4 thereof which is *in pari materia* with Uganda's Article 24 of the Constitution outlaws actions that lead to loss of the right to liberty such as holding debtors captive. Therefore, physicians have no legal right to detain any person for whatever reason.

Further still, Article 16(2) of the ACHPR provides that it is the duty and responsibility of government to ensure that the sick citizens attain the necessary treatment desired in such situations without prejudice to one's social standing. Indeed, Uganda has put in place several measures in order to honour its undertakings under the Charter by enacting relevant

[66] Can be accessed at http://www refworld.org/docid/3ae6b3970.html(Accessed on 01st October, 2019).

[67] Available at https://au.int/en/treaties/african-charter-human-and-peoples-rights(Accessed on 01st October, 2019).

provisions of the law, although they are generally considered non-justiciable. As per the *Gideon Kilundo* case above and in the recent Kenyan case of *Emmah Muthoni Njeri v Nairobi Women's Hospital*,[68] it is clear that doctors/hospitals are not allowed to detain patients, since holding of a patient at ransom not only violates already established rules of contract law but also constitutes infringement on the freedom of movement.

Regionally, Uganda is an active partner of the East African Community and a signatory to the East African Community Treaty (the Treaty).[69] Article 118 of the Treaty requires partner countries to co-operate in the area of health. In addition, under Article 118 (a)-(i) of the Treaty, member states undertook, amongst other things, to cooperate in the areas of disease prevention, management of health delivery systems, drug polices, harmonisation of national health policies, exchange of information, and promotion of research.

The EAC has also developed a policy to guide members on how to harmonize their local legislations in order to conform to the public health-related World Trade Organization (WTO) Trade Related Aspects of Intellectual Property Agreement (TRIPS) flexibilities.[70] It is important to note that regardless of the EAC arrangement, individual states have adopted different approaches to dealing with issues of enforcing the right to health, partly attributed to the lack of political will in some countries. For example, while Kenya has progressed on the fight against patient detentions,[71] by judicial condemnation of such actions, Ugandan judges are reluctant to interpret the core rights guaranteed in the Constitution, to find violation of the right to liberty and freedom of movement.

From the above discussion, it has been demonstrated that Uganda has committed to adhering to its obligations under international law, first by domesticating instruments relating to observance and attainment of health rights. Therefore, it falls squarely on government to ensure that all national laws are streamlined in accordance with international standards so as to fully realize the aforesaid right. And specifically, the government needs to heighten fight against violation of patient's rights by some physicians, by among others, championing national legislative reform in order to end the continuous impunity in private and public

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68 Constitutional Petition No.352 of 2018.

69 The East African Community Treaty; Available at http://www.eac.int (accessed 01st October 2019).

70 For more information, see http://www.cehurd.org/wp-content/uploads/downloads/2013/05/EACTRIPS- (Accessed on 01st October, 2019).

71 *Ibid.,* note 25.

health centres. The Medical Council has issued a statement condemning the illegal detention of patients by health facilities but this is not enough! The Uganda Police has also issued a directive to its officers to apprehend private health care providers who break the law by detaining patients but this too is yet to yield any results.[72]

CHAPTER THREE

RECOURSE AVAILABLE TO VICTIMS OF RIGHTS' VIOLATIONS

3.1 Introduction

In the preceding chapter, we generally looked at the legal framework governing health rights. The conclusion reached was that whereas the international framework is robust, the national framework is lacking and thereby causing impediments to the eventual enforcement of health rights in Uganda. Therefore, this chapter will focus on the avenues available to patients who are victims of detentions by hospitals for failure to pay their bills.

3.2 Government

Conventionally, the Ministry of Health is vested with the mandate of ensuring that all obligations of the state especially those related to observance of and enforcement of objective XX of the National objectives in the Constitution are fulfilled. In Uganda, with the decentralization of services, the implementation of government programs and policies relating to the health sector are foreseen by the local governments which provide strategic leadership.

Under Article 25 of the Patients' Charter of 2009, government has delegated its mandate of ensuring strict adherence to patients' rights by empowering established committees and councils to handle complaints against health workers. However, none of these initiatives often prevent or solve the practice of patient detentions, perhaps partly explained by the non-binding nature of the Patients Charter and lack of an established institutional framework at the local government level.

[72] According to information retrieved from Uganda Police Force Website at https://www.upf.go.ug (Accessed on 21st September, 2021).

3.3 Quasi-Judicial Bodies

3.3.1 The Uganda Human Rights Commission (UHRC)

Article 51 of the Constitution establishes the UHRC with the primary mandate of ensuring that government complies with its responsibility of safeguarding human rights. In order to perform this important task, Article 52(1) (a) thereof vests the UHRC with investigatory powers so that the Commission can effectively inquire and interrogate acts of human rights violations.

In addition, under Article 52(1) (d), the Commission makes recommendations to Parliament regarding its findings, which also include recommendations for compensation of victims of rights abuses.

Furthermore, under Article 52(1) (e) of the Constitution, the body has a role of sensitizing the public about the Constitution, especially those related to observance of fundamental individual rights.

Therefore, any patient aggrieved person by the infringement of his/her right can file a case with the UHRC, which exercises powers of court in the process of determining the complaint/dispute. The UHRC has made a ruling against a major private hospital in Kampala for having detained a patient who was unable to pay $45 bill for a cataract surgery.[73]Although this pronouncement of UHRC was landmark in the area of patient detention in Uganda, it is pertinent to observe that the Commission's reports are rarely implemented by government, which occasionally ignores them. As such, despite its well-entrenched constitutional mandate and informal procedure, the UHRC's decisions are more academic than practical.

3.3.2 The Equal Opportunities Commission (EOC)

Under Articles 32(1) and (2) of the Constitution, a constitutional framework is provided for creation of EOC, thus:

> "**32. Affirmative action in favour of marginalized groups**
>
> 1) Notwithstanding anything in this Constitution, the State shall take affirmative action in favour of groups marginalised on the basis of gender, age, disability or any other reason created by history, tradition or custom, for the purpose of redressing imbalances which exist against them.

[73] Retrieved at https://www.uhrc.ug (Accessed on 14th August, 2019).

2) Parliament shall make relevant laws, including laws for the establishment of an equal opportunities commission, for the purpose of giving full effect to clause (1) of this article."

Therefore, pursuant to Article 32 clause 2 thereof, the Equal Opportunities Commission Act of 2007 was passed.[74] Under section 2(1) of the Act, the Equal Opportunities Commission (EOC) is established.

Under section 14(3) of the EOC Act, the Commission is empowered to settle a dispute through alternative options without the need for a fully-fledged hearing which is time consuming and expensive for the litigants. Furthermore, under section 14(4) of the Act, the mandate of EOC extends to practices by any institution or individual that exhibit tendencies of discrimination or marginalization against other persons or individuals. In this context, we would be right to suggest that the recurrent practice of detaining persons who fail to pay medical arrears falls within the legal jurisdiction of the EOC.

Section 15(1) of the Act entrusts the Commission with judicial powers to summon witnesses and make binding decisions just like the UHRC, in order to effectively fulfill its constitutional mandate. Therefore, in essence, the Commission was set up to operationalize the provisions of the Constitution outlawing discrimination, marginalization or otherwise undermining equal opportunities.

Since its establishment, a number of claims on discrimination, inequality, marginalization and undermining of opportunities has been filed and handled by the EOC. It is the right time for health activists to explore filing complaints especially those relating to the detention of patients by physicians for determination. However, to-date, the mandate of EOC has never been tested regarding the question of whether the continued practice of patient detentions by hospitals amounts to discrimination of such patients on account of poverty for failure to respect their constitutional rights to access health care.

3.3.3 Medical Professional Disciplinary Councils

As earlier discussed, health workers can be supervised under the provisions of the laws mentioned and also under the Patients' Charter of 2009, as herein demonstrated.

[74] The EOC Act was enacted in order to operationalize the provisions of the Constitution relating to non-discrimination, marginalization and equal opportunities for all citizens.

Under Article 19 of the Charter, provision is made for a forum of legal redress in case of violation of the rights contained therein. This provision is operationalized under Article 25 of the Charter, which entrusts disciplinary powers to the professionals' disciplinary councils discussed below, and formal courts.

However, the above provision is ambiguous since the decision to detain patients is always an administrative matter determined by the management of the hospitals or health centers rather than the individual health practitioners, hence rendering enforcement under the foregoing provisions of the Charter for disciplinary action impossible, notwithstanding that the Charter has no force of law.

A vast number of complaints that find their way to the respective disciplinary councils of the health professional bodies are brought on account of unprofessional conduct of individual medical practitioners, but not necessarily for patient detentions. We examine the complaints' procedure before such bodies below.

3.3.3.1 The Medical and Dental Practitioner's Council (the Council)

The Council is mandated *inter alia to* oversee the discipline of errant physicians by enforcing strict professional standards.[75] Under section 33 of the Act, like the UHRC, the Council can undertake independent investigation of any professional subjected to a disciplinary case and it determines appropriate sanctions in the circumstances.

In exercising its mandate, the Council takes into account the code of professional ethics and standards enumerated and required of medical professionals.[76] In addition, the Guidelines put in place are intended to guide persons aggrieved with the conduct and practice of a physician to easily lodge a complaint.

However, despite these Guidelines being in force, they are not readily accessible and persons intending to lodge complaints against health workers are either ignorant of its existence or end up using other avenues of dispute resolution. Apart from issuing statements condemning the

[75] *Ibid*., note 46, Section 3(d).

[76] See generally; The Uganda Medical and Dental Practitioner's Code of Professional Ethics, 2008 and, The Guidelines in respect of Complaints against Medical and Dental Practitioners (Guidelines).

practice of patient detentions, the Medical Council has to-date not delivered any decision sanctioning its errant members who violate the law in that regard.

3.3.3.2 The Nurses and Midwives Council (NMW Council)

The NMW Council is created with an oversight role over nurses and midwives.[77] In addition, under section 37(1) (c) of the NMA Act, a disciplinary committee is established to supervise the conduct and practice of nurses as they perform their day today duties.

According to *The Code, Standards of Conduct, Performance and Ethics for Nurses and Midwives*, these middle level providers are required to offer their services with utmost professionalism and dedication in similar terms like doctors. Therefore, these health workers should not purport to handle cases which exceed their capacity, in which case they have a moral and legal duty to refer the matter to the attention of a health professional.

3.3.3.3 The Allied Professional's Council (AHP Council)

The AHP Councils established with the mandate of regulating the conduct of Allied Health Professionals and to also offer a supervisory role.[78] Furthermore, under section 37 of the Act, a disciplinary committee is created to handle complaints arising from the misconduct of Allied Health Professionals.

3.4 The Courts of Law

> "*Any health worker who contravenes these rights may face appropriate disciplinary actions from Health Unit Management committees, Health Professional Councils, Medical Boards, and Courts of law."*
> (Article 25 of the Patients' Charter of 2009)

An aggrieved person may also approach the courts for legal solutions through actions filed under the appropriate enabling legal provisions. One approach is to invoke Article 50(1) of the Constitution in order to enforce violated rights or rights threatened with violation. It provides, thus:

> **50. Enforcement of rights and freedoms by courts.**
>
> (1) Any person who claims that a fundamental or other right or freedom guaranteed under this Constitution has been infringed or threatened is entitled to apply to a competent court for redress...[79]

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[77] *Ibid.*, note 48, Section 3(1)(b).
[78] See; the Allied Health Professional Act, Cap 268
[79] *Ibid*.,note 2, Art. 50 (1).

The above provision is important in so far it opens doors for relief from courts in the event a person's fundamental right stipulated therein are violated.

Further, in situations where the victim of the rights violations is unable by himself/herself to go to court, such as in cases of deceased victims, Article 50(2) allows class actions. This provision, states thus:

> *Any person or organization may bring an action against the violation of another person's or group's human rights.*

Pursuant to the above constitutional provision, organizations such as CEHURD have been able to move Court to offer legal redress to victims of rights abuses. In *Greenwatch v AG & NEMA*,[80] the Applicants who did not have a clear cause of action exploited the provisions of Article 50(2) to have locus in court.

Furthermore, Article 50(1) of the Constitution strengthens courts to offer remedies which include awarding compensation for such violations of the fundamental or other rights and freedoms guaranteed in the Constitution. On account of Article 50 thereof, many actions have been brought to court for purposes of judicial scrutiny and determination.[81]

In addition, a petition can be filed for determination where questions arise as to the legality and constitutionality of a given law or practice.[82] Article 137 (3) states, thus:

> "Article 137 (3) A person who alleges that—
>
> (a) an Act of Parliament or any other law or anything in or done under the authority of any law; or
>
> (b) any act or omission by any person or authority,
>
> is inconsistent with or in contravention of a provision of this Constitution, may petition the constitutional court for a declaration to that effect…"

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80 *Greenwatch v Attorney General and National Environment Management Authority* (Misc. Cause 140/2002), find at https://ulii.org/ug/judgment/high-court/2012/205). (Accessed on 19th February, 2020).

81 These include; Law suits by *CEHURD & Rose Obigah v International Medical Group (*Civil Suit No.571/16*)*, where the Petitioners sought court's declaration as to whether it is legal for the Defendant hospital to detain patients for failure to clear their medical bills. Furthermore, see the *Nakaseke* and *Initiative for Social Change & Economic Rights'* cases on maternal and education rights.

82 *Ibid*., note 2, Art. 137(3).

Therefore, the grounds upon which one can legally petition the Constitutional court are situations where he/she seeks to challenge either any law or act by any person in which case it is argued to be in variance with the Constitution. Article 137(3) like Article 50(1) does away with the *locus standi* requirement, thereby implying that any person or organization is at liberty to move the Court.

It is because of the above provision that CEHURD and other rights activists have managed to file several constitutional petitions. We are yet to receive a constitutional petition challenging the persistent detention of patients by hospitals (private and public) for failure to pay medical bills. This can be challenged in court as an act violating a patient's constitutional rights to health care, which though not justiciable, can be discerned from the Constitution, Article 8A and Principle XX of the Objectives in the Constitution. Indeed an attempt has been made this far, and we await a decision of court on the question of constitutionality of patient detention in Uganda,[83] given that neighboring Kenya has already ruled that it is unconstitutional to hold a patient for accrued medical bills.[84]

3.5 Conclusion

The above chapter has discussed avenues available to victims of patients' detentions to wit; administrative, non-administrative and court-based remedies. Administrative procedures established in the Patients Charter, 2009 are rarely adhered to and so are the decisions of quasi-judicial bodies like UHRC and EOC which are not taken seriously, despite the fact that these institutions are established by law to offer legal redress, in this context the illegal practice of patient detentions. The chapter has further elaborated that there exists professional medical disciplinary bodies with the legal mandate of enforcing codes and standards of practice for medics. However, of all the above options, the remedy through courts stands out as the most effective way of enforcing the violation of patient's rights by hospitals. This is so because decisions of courts have more binding force than that of administrative bodies, and further that the violation of patient's rights is not only a constitutional violation but it also offends the cardinal principle of freedom of contract. It is therefore hoped, that through continuous strategic litigation, issues of patient detentions for failure to pay medical bills will be treated seriously by government and other stakeholders.

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83 *Ibid*., note 76, CEHURD & Rose Obiga case.
84 *Ibid*., note 25.

CHAPTER FOUR

USING STRATEGIC LITIGATION AS A TOOL IN ADVANCING HUMAN RIGHTS PROTECTION

4.1 Introduction

The last chapter discussed different avenues available to patients whose rights have been violated and concluded that strategic litigation seems to stand out as the best remedy to their plight. This chapter which is comparative in nature, will discuss strategic litigation in jurisdictions such as Kenya, South Africa and India. Leading cases will be explored. It will be apparent that in the profiled cases litigants invoked the provisions of internal and international law to establish that their governments have a constitutional duty of facilitating access to health services to citizens.

4.1.1 Kenya

The Republic of Kenya is a neighbouring country to Uganda and is signatory to several international treaties such as the UDHR, which guarantee the protection and enforcement of the right to health. Unlike Uganda, Kenya has enacted progressive laws aimed at reconciling its obligations stipulated in domestic as well as international law. For instance, in 2010 Kenya enacted a new Constitution which improved on adherence to human rights among others. It is therefore clear and express that under Kenya's law, health rights are justiciable unlike in Uganda. Article 43(1) of the Kenyan Constitution, states, thus:

> "**43.** (1) Every person has the right—
> (*a*) to the highest attainable standard of health, which includes
> the right to health care services, including reproductive health care"

From the above, it is discernable that it is easier to realize individual's health rights in Kenya unlike in Uganda where the right is found in Objective XX of the Constitution and largely regarded not justiciable. In *Ochieng & Others v Attorney General*,[85] it was decided that the provisions of the Anti-Counterfeit law of Kenya were contrary to the state's constitutional obligations to the population. The impugned Anti-Counterfeit Act placed serious limitations

[85] *Ibid*., note 10,para. 84.

on accessibility of essential drugs for HIV & AIDs. To the court, this restriction was unnecessary in the circumstances in view of government of Kenya's obligations to its citizens discussed above.

Therefore, as a result of the gains achieved in the Ochieng case, activism for health rights intensified. In the case of *Gideon Kilundo v Nairobi Women Hospital*,[86] in a case which involved a patient who had been detained by the Defendant hospital for failure to pay his accrued treatment expenses, the Kenyan court held that it was illegal and unconstitutional to detain patients since there are other lawful mechanisms of recovering debts. More recently, in the case of *Emmah Muthoni Njeri v Nairobi Women's Hospital,*[87] the Court declared the detention of the petitioner (patient) for 6 months for failure to pay her medical bill a violation of her dignity, right to freedom and security of the person, and the right to freedom of movement.

4.1.2 South Africa

South Africa is yet another African country with progressive laws and judicial decisions. South Africa is privy to most human rights instruments dealing with health rights, and it has gone further to make clear provisions under its domestic law to that effect. Unlike Uganda, under Article 27 of the Constitution of South Africa of 1996, the right to access health services is justiciable. Article 27(1) thereof states, thus:

> "**Health care, food, water and social security**
> 27. (1) Everyone has the right to have access to –
> (a) health care services, including reproductive care;
> ..."

The said Article is located within the main body of the Constitution and is therefore enforceable. In addition, Article 27 clause 2 of the Constitution goes further to compel the government to take effective measures for the full realization of the right to health, thus:

> "The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights."

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86 *Ibid.*, note 25.
87 *Ibid*., note 68.

As a result of the above command, South Africa enacted the National Health Act[88] which is supposed to operationalize Article 27 of the Constitution.

Similarly, due to significant judicial activism in the country, litigants have achieved great successes. In *Minister of Health v Treatment Action Campaign*,[89] the Respondent, a human-rights based body challenged the policy not to provide essential medicine to South Africans. The South African court, decided, *inter alia*, that this restriction on access of the drug was unreasonable and unconstitutional.This decision was a big achievement for not only litigants in South Africa but human rights champion's across the world.

4.1.3 India

India is another country from which Uganda can pick lessons in terms of its progressive laws and court decisions especially those interpreting health rights. It is without doubt that these rights are justiciable in the Constitution of India. This is so because India just like Uganda has objectives in the Constitution, however, courts in India have gone further to harmonize the national objectives and fundamental rights guaranteed in the Constitution. In *Kesavanda Bharat v State of Kerala & Another*,[90] court held that where fundamental rights are affected, it is plausible for a judge to read into those provisions holistically and not to disregard the national objectives even though not located within the main body of the Constitution. This is a lesson to Ugandan judges who are hesitant to harmonize the objectives and other co-related rights in the Constitution.

Additionally, in the case of *Laxmi Mandal v Deen Dayal Harinagar Hospital*,[91] the Delhi High Court decided that it is the duty of the state to facilitate access to health services, namely, maternal health care to all citizens. This case raised awareness about government's unpopular policies on health matters and augmented the need for reform in health sector policies in India. Further, the precedent set a pace for using national laws to support fundamental rights generally and armed activists with an incentive for providing checks and balances to government.

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88 The National Health Act No. 1 of 2003, Laws of South Africa. Find at www.section27.org.za › wp-content › uploads › 2010/03 › national-health. (Accessed on 16th February,2020)

89 *Ibid*., note 11.

90 *Ibid*., note 12.

91 *Ibid*., note 9.

4.2 Analysis

The discussion above shows that litigants in those countries based on the right to health, which is justiciable in their state constitutions to demand their governments to implement right to access of health services. In those countries, the duty of government to protect this right is expressly provided in the law, making it easier to enforce, unlike in Uganda. The courts were simply interpreting the constitution and finding existence of the violation of the right guaranteed therein.

In Kenya, the court's judgment was significant not only to HIV patients in the country but to those in other countries like Uganda. For instance, civil society organizations like CEHURD borrowed the example to champion for maternal rights in Uganda as per earlier discussion on this matter. The decision was also supplemented by media advocacy which was important to sensitize people about their rights and to hold perpetrators to account.

All of the profiled cases show that strategic litigation can eventually bring about extensive, universal change since it can compel courts to enforce justiciable rights to a greater extent and non-justiciable rights to a limited extent, as was in the *Kesavanda Bharat* case,[92] in which the court harmonized the Objectives and fundamental rights, hence finding the rights justiciable. It is thus possible for Ugandan judges to adopt the Indian experience in that case of closely interpreting the National objectives which expressly mentions health rights and harmonizing the same with the bill of rights in order to find the right justiciable. In this context, a liberal approach should be adopted in interpreting the said provisions alongside other constitutional provisions aforementioned, in order to find that the practice of patient detentions by physicians is illegal and unconstitutional. Uganda's neighbor Kenya, offers another example for instance in the *Gideon Kilundo* case,[93]where court found the practice of detaining patients for failure to pay medical bills arbitrary, unlawful and unconstitutional. The Judge remarked that there are so many avenues of recovering debts, and this does not include holding a patient captive.

The cases above had far reaching implications to other countries such as Uganda. In Uganda, strategic litigation has contributed to rapid legislative reforms such as; enactment of The

[92] *Ibid.*
[93] *Ibid.*,note *25.*

Human Rights (Enforcement) Act, 2019 and The Judicature (Fundamental and other Human Rights and Freedoms) Enforcement Procedure) 2019; both of which were largely passed due to pressure resulting from strategic litigation.

4.3 Conclusion

From the foregoing, it has been demonstrated that patient detentions can be challenged successfully in court. Through strategic litigation, courts found that the governments of countries above failed to fulfill their minimum constitutional obligations especially those relating to supervision of the health sector. Strategic litigation is and has been an effective tool in challenging rights violations in the broader context of maternal rights as well as patient's rights like in the Kenyan case of *Gideon Kilundo v Nairobi Hospital*[94] and other profiled cases in India and South Africa discussed above.

[94] *Ibid.*

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1 Recommendations

In the earlier chapters it was shown that it is both unreasonable and illegal for physicians to hold patients incommunicado, to threaten and intimidate them for accrued medical bills. The patient and the physician have a legally binding contract with obligations that an aggrieved party can pursue enforcement. Most recently, the Ugandan media has been awash with newer incidents of patient detentions at St. Francis Hospital Naggalama, where the hospital detained four mothers and their newly born babies for failure to pay bills ranging between Shs. 200,000/= and Shs. 800,000/=.[95]

The widespread practice of patient detentions for accrued medical bills is not only disrespectful but abusive to patients, and calls for immediate intervention by all the stakeholders tasked with the duty of protecting health rights in Uganda. Many of the solutions to curb this vice are intended at addressing the many cases of social-economic imbalance in the society, since this practice deviates from well-established principles of human rights (national and internationally), and specifically safeguard of the right to liberty, independence, free-will, and freedom from intimidation.

Perhaps, a more feasible approach to patient detention appears to be strategic litigation in order to assert the justiciability of health rights, though considered non-justiciable in Uganda. In this regard, strategic litigation should be based, firstly, on the unambiguously known rights such as; the right not to be discriminated, the right to personal freedom, the right to life, the right to privacy and other related rights from which courts can read in and enforce patient's rights. In this context, human rights advocates should furnish the courts with relevant progressive jurisprudence from India, South Africa and Kenya which have transcended all legal barriers towards enforcing the right to health in their countries.

[95] As per The Daily Monitor Newspaper, Issue of 14th October, 2019 at page 4 thereof.

In addition, health authorities, health workers and professionals who are directly or indirectly responsible for patient detentions should personally be dragged to court for not only medical negligence like it was in the Nakaseke and Mulago cases but for other rights' violations. The Judge in the Nakaseke case was bitter that the doctor who attended to the deceased was not added as a party. Furthermore, the complaints management system needs to be streamlined in order to instil public confidence. In addition, there should be increased campaign among the public about they can realize their health rights through the different channels.

More practically, the Constitution ought to be amended in order to clearly and unequivocally make binding provisions with regards to health rights and particularly patient's rights, as it is with the Republics of Kenya and South Africa. In the same regard, civil society organizations and other health rights players need to advocate for law reform, as a way of streamlining the fight for patient's rights.

In addition, a legislation operationalizing Article 8A needs to be urgently passed so as to promote the socio and economic rights stipulated in the National objectives and therefore, the Legislature should expedite the passing of the Patient's Rights and Responsibilities Act, 2019 as substantive health legislation as is the case for South Africa.[96] There is need to reconcile all the conflicting provisions in the laws for purposes of fostering harmony of rights guaranteed therein.

Obviously, Civil Society Organizations should continue advocating for significant reforms in the health sector especially those tailored towards increasing access to health services in the country. For instance, through mass advertisements on media and other for a about the importance of a healthy population towards national development, thereby compelling government to streamline health sector as a priority in the annual budget.

The numerous and confusing health policies should be harmonized, but most importantly implementation of the same should be expedited since most of them lack a strategic resource to become useful. In the same vein, other activists should emulate the vigilance and persistent on championing human rights by CEHURD. United we stand and divided we fall. Further, Ugandan judges should learn from their colleagues in other jurisdictions who have on numerous occasions enforced the right to health in their countries' constitutions, thereby

[96] *Ibid*., note 88.

finding this right justiciable. As has been appreciated most recently in Petition No.16 of 2011, Uganda's constitutional court affirmed obligations of Government to provide health care and medical services in Uganda.In that landmark case, the right to health was found to be justiciable in Uganda, finally!

5.2 Conclusion

It is hoped that the Patient's Rights and Responsibilities Bill, 2019, which had been shelved, will be passed into law, now that it is back before the August house. This study has demonstrated that strategic litigation is a powerful tool that advocates for health rights can use to champion for the rights of patients against detention by health centers. Ugandan courts need to be proactive and embrace judicial activism which will enable them to find the right to health justiciable even though generally not considered justiciable. Examples should be drawn from progressive jurisdictions like India, South Africa and neighbouring Kenya like has been discussed above.

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UNIVERSITY OF KWAZULU-NATAL

EXEMPTION FROM ETHICS REVIEW APPLICATION FORM: 2014 (HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE)

Preamble

Research studies that qualify for exemption from ethics review include those employing the method of review of *materials available in the public domain* such as:
- Newspapers, websites, magazines, public reports, public statements, films, television programs, public performances, public exhibitions, public speeches
- Published works, systematic reviews, literature reviews, collective reviews
- Archived materials that are available in the public domain

Studies involving the *review of archived materials that are confidential* (e.g. hospital/ clinic case notes, medical records) must be ethically reviewed and are **not** exempt (although they may qualify for expedited approval). Studies of closed social media sources/fora require ethics review.

Studies involving the review of departmental/institutional statistics, (employees, clients, patients, service providers and users) service records etc must be ethically reviewed and are usually **not** exempt.

Studies that employ *additional methods* involving direct contact with human participants such as interviews, focus groups etc., over and above or in addition to review of materials in the public domain are **not** exempt.

The status of a study's ethics review exempt status can only be made by the REC chair and not by the applicant or another third party.

Updated: 20 March 2014

PLEASE NOTE THAT THE FORM MUST BE COMPLETED IN TYPED SCRIPT. HANDWRITTEN APPLICATIONS WILL NOT BE CONSIDERED

SECTION 1: PERSONAL DETAILS

1.1	**Surname of Applicant :**	Aruho
1.2	First names of applicant:	Amon
1.3	Title (Ms/ Mr/ Mrs/ Dr/ Professor etc) :	Mr
1.4	Applicant's gender	: Male
1.5	Applicant's Race (African/ Coloured/Indian/White/Other)	: African
1.6	Student Number (where applicable)	: 219084436
	Staff Number (where applicable)	:
1.7	School	: School of law
1.8	College	: law and Management Studies
1.9	Campus	: Howard
1.10	Existing Qualifications	: DDPH (MPS), LLB (MUK), DLP (LDC)
1.11	Proposed Qualification for Project (In the case of research for degree purposes)	: LLM (Medical law)

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3.3				

SECTION 2: PROJECT DESCRIPTION

2.1 Project title

Advancing Human Rights in Patient care through strategic litigation the case of Uganda.

2.2 Questions to be answered in the research

- How rampant is the practice of detention of Patients' in Medical facility for failure to pay medical bills in Uganda?
- Which laws in Uganda provides for Human rights in Patient care ?
- Which laws in Uganda addresses the practice of detention of Patients' in medical facility for failure to pay medical bills?
- Which international Instruments has Uganda ratified to, that have a bearing on Human rights' in patient care?
- What have courts of law adjudicated upon violation of Human rights' in Patient care in Uganda?
- What has the government of Uganda done to address this practice of detention of patients by Health facilities for failure to pay medical bills?
- What lessons can Uganda learn from neighboring jurisdiction in regard to addressing the practice of detention of patients' in Medical facility for failure to pay medical bills?
- What can be done to improve on the practice of human rights protection during patients' care in Uganda?
- What can be done to eradicate the practice of detention of Patients by Health facilities for failure to pay medical bills

2.3 Research approach/ methods

This dissertation is based purely on literature review. Both primary and secondary sources of law are to be consulted. Primary sources of law that are canvassed include the constitution, international statutes that Uganda has ratified to, the common law, case law, national legislations, government policy documents and several reports and regulations promulgated thereunder, as it pertains to human rights in patient care. Authoritative textbooks and academic articles are to be consulted as secondary sources of law.

SECTION 3: FORMALISATION OF THE APPLICATION

APPLICANT

I have familiarized myself with the University's Code of Conduct for Research and undertake to comply with it. The information supplied above is correct to the best of my knowledge.

DATE: 30th April 2019 SIGNATURE OF APPLICANT .....[redacted].....

SUPERVISOR/PROJECT LEADER/DISCIPLINE ACADEMIC LEADER

[redacted]

DATE: 01 May 2019

SIGNATURE OF SUPERVISOR/ PROJECT LEADER/DISCIPLINE LEADER

_____

RECOMMENDATION OF SCHOOL RESEARCH ETHICS COMMITTEE/HIGHER DEGREES COMMITTEE

The application is (please tick):

	Recommended and referred to the Human and Social Sciences Ethics Committee for further consideration
	Not Approved, referred back for revision and resubmission

NAME OF CHAIRPERSON:

_____**SIGNATURE:**_____

DATE **……**

RECOMMENDATION OF UNIVERSITY RESEARCH ETHICS COMMITTEE (HUMAN AND SOCIAL SCIENCES)

The application for Exemption is (please tick):

	Approved by Chairperson
	Not Approved. Sent back for further clarity and resubmission

If approved, the Exemption Number to be recorded: _____

NAME OF CHAIRPERSON:_____**SIGNATURE**_____ __

DATE...……