THE ROLE OF NON-GOVERNMENTAL ORGANISATIONS (NGO'S) IN THE REALISATION OF THE RIGHT TO HEALTH

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DECLARATION

I ATUHEIRWE DOREEN do hereby declare that this dissertation was carried in accordance with the requirements of the university regulations and that it has not been submitted for any other academic award. Other works cited or referred to accordingly acknowledged.

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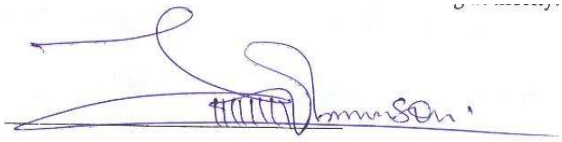
APPROVAL

This dissertation by Atuheirwe Doreen under the title 'The role of Non-Governmental Organisations (NGO's) in the realisation of the right to health' has been under my supervision and is approved for submission to the examining authority.

Signature: 

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DEDICATION

This research paper is dedicated to my family especially my mother and father Mr. Kyoheirwe Ferdinand and Mrs. Ninsiima Cleophas for the confidence and encouragement they have instilled in me to complete this work and for believing in me, to my siblings Agasha Martha Tricia, Aheirwe Christian, Ayebale Joannah for their support, encouragement, inspiration and prayers to enable me finish this work successfully.

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'MAY THE ALMIGHTY GOD REWARD YOU ALL ABUNDANTLY'

TABLE OF CONTENTS

LIST OF ABBREVIATIONS

ACHPR –African Charter on Human and People's Rights

CEDAW –Convention on the Elimination of All Forms of Discrimination Against Women

CEHURD –Center for Health, Human Rights and Development

CRC –Convention on the Rights of the Child

CRC –Convention on the Rights of the Child

CRPD –Convention on the Rights of Persons with Disabilities

CRPD –The Convention on the Rights of Persons with Disabilities

DFID –Department for International Development

ICESCR –International Convenant of Economic, Social and Cultural Rights

ISER –Initiative for Social and Economic Rights

NGOs –Non-Governmental Organisations

UNHCO –Uganda National Health Consumers' Organisation

USAID –United States Agency for International Development

ABSTRACT

This research study discusses NGO's role in realising the right to health in Uganda, with a particular focus on NGO's. It explores the legal and non-legal aspects governing role of NGO's in realization of the right to health. It is a combination of library data collection analysis and doctrinal research it identifies the challenges that affect NGO's in the realization of the right to health, the comparative models between South Africa and India in the way they handle the right to health and how Uganda as a country can adopt some of the methods and ways they use in making the right to health a fundamental human right for its population.

This study recommends various amendments in the statutory laws of Uganda such as the Public Health Act, NGO Act and The Constitution of the Republic of Uganda 1995, as Amended, to acknowledge the right to health as a fundamental human right.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background to the Study

The right to health is universally recognised as a fundamental human right, essential for the enjoyment of all other rights. It is articulated in various international instruments, most notably the **International Covenant on Economic, Social and Cultural Rights (ICESCR), under Article 12** proclaims "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." **The Committee on Economic, Social and Cultural Rights (CESCR), in General Comment No. 14,** expands this right to encompass both access to healthcare services and the broader social determinants of health such as access to clean water, adequate nutrition, shelter, and environmental conditions conducive to well-being.1

Regionally, **the African Charter on Human and Peoples' Rights (ACHPR) affirms in Article 16** that "every individual shall have the right to enjoy the best attainable state of physical and mental health." Uganda, as a signatory to these instruments, has undertaken legal commitments to ensure that its citizens enjoy these rights.

Domestically, although the Constitution of the Republic of Uganda 1995, as Amended does not explicitly enshrine the right to health as a justiciable right**, National Objective XX of the National Objectives and Directive Principles of State Policy** requires the state to ensure the provision of basic medical services. Additionally, **Article 45**[2]

[1] UN Committee on Economic, Social and Cultural Rights (CESCR). (2000). General Comment No. 14: The Right to the Highest Attainable Standard of Health.
[2] The Constitution of the Republic of Uganda 1995, as Amended

provides interpretive room for recognising unenumerated rights, especially those derived from international obligations.

Despite these commitments, Uganda continues to struggle with the practical realisation of the right to health. Challenges include underfunded public health infrastructure, inadequate human resources, stock-outs of essential medicines, and disparities between urban and rural healthcare services. These systemic problems disproportionately affect vulnerable groups, including women, children, persons with disabilities, and those living in poverty or remote areas.[3] In this context, Non-Governmental Organisations (NGOs) have become indispensable actors in the health sector. NGO's provide about 30% of Uganda's health services and engage in services such as service and health education delivery, advocacy for rights, and emergency response.[4] This is a source of concern regarding accountability, equity, and sustainability, and more so about Uganda's human rights commitments.[5] However, their roles are not regulated within Uganda's legal framework. This raises critical concerns about accountability, equity, and sustainability, particularly considering Uganda's human rights obligations.

NGOs have filled vital gaps in service provision where government capacity is limited, particularly in rural and underserved communities. Some NGOs bring specialized expertise, donor funding, and community-based approaches that strengthen health outcomes. Others play a watchdog role, advocating for policy reforms and holding the

[3] World Health Organization. (2020). Health Workforce Requirements for Universal Health Coverage and the Sustainable Development Goals. Geneva: WHO.
[4] Ibid
[5] Ibid

government accountable to its legal obligations. However, the absence of NGO co-ordination, fragmented interventions and variable commitment to rights-based approaches can undermine the coherence and performance of their duties[6] to its legal obligations. However, the absence of NGO coordination, fragmented interventions, and variable commitment to rights-based approaches can undermine the coherence and performance of their duties.[7]

1.2 Statement of the Problem

Though NGO's bridge important gaps in Uganda's healthcare system, their role towards the realisation of the right to health has yet to comprehensively examined from a human rights-based and legal perspective. Although beneficial in many respects, the proliferation of NGO activities in health service delivery has occurred in a regulatory vacuum, raising questions about oversight, legal compliance, coordination with state actors, and adherence to human rights standards. The absence of a robust legal framework integrating NGOs within the national health and human rights infrastructure risks undermining Uganda's international obligations and Constitutional responsibilities.

Moreover, NGOs may inadvertently create parallel systems of service delivery that lack consistency and long-term sustainability. Without a legal mandate to adhere to the Human Rights-Based Approach (HRBA) principles and the AAAQ framework (Availability, Accessibility, Acceptability, and Quality), NGOs may fall short in fulfilling the essential

[6] Katsiaouni, O. (2023). Civil Society and Health Governance in Sub-Saharan Africa: Rethinking Partnerships. International Journal of Human Rights, 27(2), Pg.148-164.
[7] Katsiaouni, O. (2023). Civil Society and Health Governance in Sub-Saharan Africa: Rethinking Partnerships. International Journal of Human Rights, 27(2), Pg.148-164.

elements of the right to health. This study seeks to critically examine these gaps and propose doctrinal, legal, and policy reforms.

1.3 Objectives of the Study

1.3.1 General Objective

This research was carried out to critically analyse the role of NGO's in the realisation of the right to health in Uganda through a doctrinal and human rights-based approach.

1.3.2 Specific Objectives:

- To examine the legal and normative content of the right to health under international, regional, and domestic law.
- To evaluate the contribution of NGOs to health service delivery in Uganda considering Uganda's legal obligations.
- To assess the extent to which NGO health interventions align with HRBA principles and the AAAQ framework.
- To propose legal and policy reforms to enhance NGO accountability and coherence with the right to health.

1.4 Research Questions

1. How is the right to health defined and interpreted under international, regional, and national law applicable in Uganda?
2. What are the roles and responsibilities of NGOs in Uganda's health sector, and how do they relate to state obligations under human rights law?

3. To what extent does Uganda's legal and policy framework support or undermine NGO efforts in the realisation of the right to health?
4. What reforms are necessary to ensure that NGO interventions conform to the Human Rights-Based Approach and Uganda's legal obligations?

1.5 Justification of the Study

As Uganda continues to face significant public health challenges, the role of non-state actors becomes increasingly central to the realisation of the right to health. However, legal scholarship has often failed to interrogate the operations of NGOs through a human rights-based perspective. This study fills that gap by applying a doctrinal methodology to assess whether NGO contributions are consistent with legal standards and Uganda's obligations under international law.

The findings of this study will serve multiple stakeholders. For policymakers, it offers a critical evaluation of the existing legal and institutional framework and proposes tangible reforms. For NGOs, it provides normative guidance to align interventions with human rights principles. For scholars, it contributes to the growing discourse on health rights, governance, and non-state actors. Ultimately, the study advances the broader goal of health equity and social justice in Uganda.

1.6 Scope of the Study

1.6.1 Subject Scope

This study primarily focuses on the intersection between the right to health and the role of Non-Governmental Organisations (NGOs) in Uganda. It adopts a doctrinal legal approach to examine the extent to which NGO-led health interventions align with

international, regional, and domestic legal obligations and standards, particularly those articulated in the ICESCR, ACHPR, and Uganda's Constitution. The study further analyses the incorporation of the Human Rights-Based Approach (HRBA) and the AAAQ framework (Availability, Acceptability, and Quality) into the legal and operational frameworks governing NGOs.

1.6.2 Geographical Scope

The geographical focus of this study is Uganda. The research examines the legal and policy environment within which NGOs operate in Uganda's health sector, drawing from national legislation, judicial decisions, and health governance structures. References to international best practices and comparative experiences, such as those from South Africa and India, are included to provide contrast and inform recommendations, but the primary emphasis remains on Uganda.

1.6.3 Temporal Scope

The study covered the contemporary period, with emphasis on the post-1995 Constitutional era, when the current legal framework of Uganda was enacted. References include developments from 1995 to the present, with particular focus on laws, policies, and case law relevant to health rights and NGO regulation. Where applicable, historical context is drawn upon to explain the evolution of legal and institutional practices.

1.7 Significance of the Study

The right to health is foundational to human development and dignity. Understanding how it is operationalised through legal and non-legal frameworks is vital to advancing social justice. This study is significant in several respects:

First, it provides a unique doctrinal lens through which to assess NGO contributions, a relatively underexplored area in Uganda's legal scholarship. Second, it identifies gaps and ambiguities in the legal and policy frameworks regulating NGOs, proposing concrete recommendations for reform. Third, it enriches the understanding of how international and regional health rights norms can be domesticated through national legal systems. Finally, the study seeks to contribute to a more equitable, participatory, and rights-based health system in Uganda.

1.8 Structure of the Dissertation

Chapter One introduces the study, outlining the background, problem statement, objectives, research questions, justification, scope, and significance. Chapter Two explores the non-legal contributions of NGOs to the right to health, including service delivery, community mobilisation, advocacy, and health education. Chapter Three conducts a comprehensive doctrinal analysis of the international, regional, and domestic legal frameworks governing health rights and NGO regulation. Chapter Four synthesises the findings, presents conclusions, and offers legal and policy recommendations aimed at enhancing the role of NGOs in the realisation of the right to health in Uganda.

1.9 Literature Review

Several scholars and institutions have examined the right to health from both normative and operational perspectives. **General Comment No. 14 by the CESCR** lays the foundation for understanding the legal obligations of states in realising health rights. It highlights the AAAQ framework as a practical standard for evaluating health systems. Meanwhile, regional instruments like ACHPR further reinforce state duties to ensure equitable health access.

Kyaddondo and Nangendo identify the significant footprint NGOs have left in Uganda's health sector, especially in rural areas, where they fill critical service delivery gaps[8]. Their work underscores the dependency of Uganda's public health system on external actors.

Similarly, the Uganda NGO Forum[9] provides a civil society perspective on the strengths and weaknesses of NGO involvement, noting issues of coordination and the uneven integration of rights-based approaches. Recent contributions from Katsiaouni[10] provide a critical lens on civil society's role in Sub-Saharan health governance, arguing that NGOs can either reinforce or undermine health systems depending on how they align with national structures. The World Health Organization[11] and the Ministry of Health[12]

[8] The Role of NGOs and the private sector in health care provision in Uganda by Kyaddondo, D. & Nangendo, F. (1998) Pg.25

[9] Uganda NGO Forum. (2021). State of Civil Society Report 2021: The Role of NGOs in Health Sector Governance. Kampala: Uganda NGO Forum.

[10] Katsiaouni, O. (2023). Civil Society and Health Governance in Sub-Saharan Africa: Rethinking Partnerships. International Journal of Human Rights, 27(2), 148-164.

[11] World Health Organization (WHO). (2020). Uganda: Health Profile 2020. Geneva: WHO.

[12] Ministry of Health. (2016). Annual Health Sector Performance Report 2015/2016. Kampala: Government of Uganda.

reports offer empirical data on Uganda's public health infrastructure, revealing systemic deficiencies that often necessitate NGO intervention.

Other scholars, such as Gruskin[13] and Backman[14], have developed conceptual frameworks for applying human rights principles to health policies and programs. They emphasise participation, accountability, and non-discrimination as critical elements in realising the right to health. These works inform the analytical lens of this study, particularly regarding whether NGO interventions in Uganda meet such standards.

Furthermore, comparative studies from South Africa illustrate how legally mandated rights-based approaches and robust civil society engagement have contributed to improved health outcomes.[15] These examples offer valuable lessons for Uganda, especially in integrating NGO efforts into a coherent, legally backed national health strategy. Despite this growing body of literature, there is limited scholarly analysis on the legal frameworks governing NGOs' involvement in health service delivery, particularly through a human rights lens. This study seeks to fill that gap by applying doctrinal legal analysis to determine whether NGO contributions to the health sector align with Uganda's Constitutional and international obligations.

[13] Gruskin, S., Mills, E. J., & Tarantola, D. (2007). History, Principles, and Practice of Health and Human Rights. The Lancet, 370(9585), 449–455.

[14] Backman, G., Hunt, P., Khosla, R., Jaramillo-Strouss, C., Fikre, B. M., Rumble, C., & Tarco, D. (2008). Health Systems and the Right to Health: An Assessment of 194 Countries. The Lancet, 372(9655), 2047–2085.

[15] Coovadia, H., Jewkes, R., Barron, P., Sanders, D., & McIntyre, D. (2009). The Health and Health System of South Africa: Historical Roots of Current Public Health Challenges. The Lancet, 374(9692), 817–834.

CHAPTER TWO

2.0 NON-LEGAL ASPECTS OF THE ROLE OF NGOS IN THE REALISATION OF THE RIGHT TO HEALTH IN UGANDA.

2.1 Introduction

While legal frameworks establish the normative basis for the right to health, the actual realisation of this right in Uganda, particularly in underserved and vulnerable communities for example urban slum dwellers, rural populations, refugees and is heavily influenced by the activities and interventions of Non-Governmental Organisations (NGOs). These organisations have emerged as vital actors in health promotion, service delivery, advocacy, and capacity-building. These roles are usually outside formal and legal frameworks but are still at the heart of promoting health outcomes and the progressive realization of the right to health. This chapter provides an in-depth examination of the non-legal roles of NGOs in the health sector in Uganda, including service delivery, community mobilization, health education, advocacy, emergency response, partnerships, and operational challenges. The analysis further draws from Uganda-specific examples and relevant international literature to comprehensively assess their impact. The health sector in Uganda is marked by glaring inequalities in access, quality and availability of services between regions and population groups. Maternal mortality, child mortality and the burden of diseases are some of the health challenges that exhibit persistent disparities, especially between urban and rural areas.

Most maternal health care issues in Uganda are dealt within the context of its health, population, economic policies and programmes and maternal health care must be inter alia be based on those policies and programmes. Uganda, like most of the Sub-Saharan Africa has been forced to adopt World- Bank- IMF Structural Adjustment Programmes (SAP's) which take form of trade liberalization and privatization[16].

The institutional Framework which has been put in place to protect the health of the people during the planning process are the public health regulations the framework has the primary importance of ensuring that the town council is well planned and the health of the people is upheld[17].

2.2 Uganda's Health Sector Landscape: Contextual Background

The Uganda Demographic and Health Survey notes that maternal mortality remains alarmingly high, with rural women facing disproportionately higher risks due to lack of timely access to emergency obstetric care.[18]

Rural areas face severe shortages of medical personnel, essential medicines, and functional infrastructure. According to the World Health Organization (WHO), Uganda has a physician-to-patient ratio of approximately 1:25,000, far below the WHO-recommended 1:1,000[19]. This chronic shortage of health workers is compounded by inadequate remuneration, poor working conditions, high attrition rates, and brain drain

[16] Ben Kirombi Twinomugisha (2004) Protection of Rural Poor Women's Rights to maternal health care in Uganda: the case of Kashambya Sub- County, Kabale District Pg.56

[17] The role of the public health law in the planning process in Uganda case study: Kumi Town Council by Ameja Isabella Doreen.2001 Pg.31

[18] Uganda Demographic and Health Survey (UDHS). (2016). *Key Indicators Report*. Kampala, Uganda.

[19] World Health Organization. (2020). *Health Workforce Requirements for Universal Health Coverage and the Sustainable Development Goals*. Geneva: WHO

to urban areas or foreign countries[20]. These human resource gaps are among the most critical obstacles to achieving universal health coverage in Uganda.

Infrastructure and logistics present additional challenges. Many health facilities, particularly at Health Centre II and III levels, are under-equipped and poorly maintained, leading to stockouts of essential medicines, diagnostic tools, and maternal supplies[21]. Transport constraints also hinder timely referral of emergency cases, especially in geographically isolated districts such as Kaabong and Bundibugyo.

The Ministry of Health has acknowledged these systemic gaps, identifying underfunding, weak governance structures, and lack of integration among various health actors as persistent bottlenecks[22]. Health expenditure in Uganda remains significantly lower than the Abuja Declaration target of 15% of national budgets, with health sector funding heavily reliant on donor assistance[23]. This dependence limits strategic planning and long-term sustainability, particularly when donor priorities shift.

In response to these challenges, Non-Governmental Organisations (NGOs) have become indispensable actors in Uganda's health landscape. Their presence is especially notable in under-resourced regions where state provision is minimal. NGOs not only provide gaps in the provision of services but also bring new models of responding to health issues through mobile clinics, telemedicine, and community-based care models. NGOs

[20] Ibid

[21] Ministry of Health, Uganda. (2016). *Health Sector Development Plan 2015/16–2019/20*. Kampala, Uganda.

[22] Ministry of Health, Uganda. (2016). *Health Sector Development Plan 2015/16–2019/20*. Kampala, Uganda.

[23] Uganda Bureau of Statistics. (2022). *Statistical Abstract*. Kampala, Uganda.

are also important in enabling community participation, articulating the voices of vulnerable groups, and promoting good governance within health systems.

Research has also underscored the complementary nature of national health system and NGO roles. Whereas policy guidance and regulatory powers are the domain of the government, NGOs frequently provide focused programmes with better flexibility and responsiveness. Nevertheless, a lack of harmonized system of integrating NGOs into national health planning carries a risk of disintegrated provision of services and wasteful duplication of resources.

Accordingly, a grasp of the structural dynamics within Uganda's health system and the daily working realities for NGOs offers a necessary context for an assessment of their non-legal role towards the realization of the right to health. Such an environment highlights the need for collaborative governance, community engagement, and investment in health system strengthening in pursuit of equitable and sustainable health outcomes in Uganda.

Uganda's health sector is characterised by significant disparities in access, quality, and distribution of services. Rural areas face severe shortages of medical personnel, essential medicines, and functional infrastructure. According to the World Health Organization, Uganda has a physician-to-patient ratio of approximately 1:25,000, far below the WHO-recommended 1:1,000[24].This chronic shortage is further exacerbated by poor remuneration, brain drain, and logistical limitations.

[24] World Health Organization. (2020). *Health Workforce Requirements for Universal Health Coverage and the Sustainable Development Goals*. Geneva: WHO.

The Ministry of Health has acknowledged these systemic gaps, identifying underfunding, weak governance structures, and lack of integration among various health actors as persistent bottlenecks[25]. These shortcomings create a vacuum in which NGOs have stepped in to complement government efforts, filling gaps in service delivery and advocating for more equitable access to healthcare. The sanitation of Kumi Town Council, research shows that most people in the town council use pit latrines since the topography of the town is favorable for pit latrine usage[26].

2.3 Typologies and Operational Models of Health-Related NGOs

NGOs working in the health sector in Uganda can be categorised based on their core mandates and operational approaches. Service Delivery NGOs such as Mildmay Uganda, Uganda Red Cross Society, and Marie Stopes Uganda focus primarily on direct health service provision. Their services range from operating hospitals and mobile clinics to distributing essential medicines and performing surgeries. Advocacy and Rights-Based NGOs like the Initiative for Social and Economic Rights (ISER) and the Center for Health, Human Rights and Development (CEHURD) focus on promoting social justice, accountability, and health equity through advocacy campaigns, community sensitisation, and strategic litigation. Capacity Building and Training NGOs such as Amref Health Africa and Reproductive Health Uganda are involved in training health workers, building community health infrastructure, and strengthening local health systems.

[25] Ministry of Health, Uganda. (2016). *Health Sector Development Plan 2015/16–2019/20*. Kampala, Uganda.

[26] The role of the public health law in the planning process in Uganda case study: Kumi Town Council by Ameja Isabella Doreen.2001 Pg.34

Research and Policy NGOs, including the Uganda National Health Consumers' Organisation (UNHCO) and the African Centre for Global Health and Social Transformation (ACHEST), engage in health systems research, data generation, and policy dialogue to influence national health planning.

Each of these NGO categories plays a unique but interconnected role in promoting the right to health beyond the legal framework, often employing innovative and context-specific strategies that improve health outcomes among Uganda's most marginalised populations.

2.4 Service Delivery: Bridging the Health Access Gap

NGOs have been instrumental in ensuring the availability and accessibility of essential health services across Uganda. In areas where public health infrastructure is absent or inadequate, NGOs operate health centres, dispensaries, maternity units, and emergency response services. These interventions are particularly critical in conflict-affected and post-conflict regions such as northern Uganda, where NGOs like Doctors with Africa CUAMM have rebuilt primary healthcare systems and maternal health facilities[27].Various scholars have attributed the problem of maternal health care issues to insufficient training, poor relationship between the staff and the health care seekers. Under the influence of SAP's, the health care provision policy in Uganda has three main objectives: having enhanced resources to a decentralized, more effective and limited state; privatisation with a greater role of Non-Governmental Organisations (NGO's) to fill the gap of the retreating state and involving the population in health service delivery

[27] The Role of NGOs and the private sector in health care provision in Uganda by Kyaddondo, D. & Nangendo, F. (1997)

(World Bank: 1992; de Torrente & Mwesigye:1999; Mwesigye: 2002)[28]. Under decentralisation, the central government retains the functions of policy formulation, standard setting and technical support for districts[29].

Service delivery NGOs provide a wide range of services, including immunisation and child health programs, sexual and reproductive health services, HIV/AIDS prevention, testing, and treatment, and mobile clinics serving remote populations. These services help to operationalise the "availability" and "accessibility" elements of the AAAQ framework outlined in **General Comment No. 14 of the ICESCR.**[30]

2.5 Community Health Education and Promotion

Health education is a key domain where NGOs play an indispensable role. Many communities in Uganda have limited access to reliable health information due to illiteracy, linguistic diversity, and cultural beliefs that hinder the adoption of health-promoting behaviours. NGOs use diverse methods, including radio broadcasts, drama, community dialogues, and printed IEC materials, to disseminate health messages tailored to local contexts. For instance, BRAC Uganda implements community-based education programs targeting adolescent girls and women with information on menstrual hygiene, maternal health, and nutrition.[31] Similarly, Reproductive Health

[28] Ben Kirombi Twinomugisha (2004) Protection of Rural Poor Women's Rights to maternal health care in Uganda: the case of Kashambya Sub-County, Kabale District Pg.57

[29] See: Hutchinson, P. et al (1999).

[30] The Role of NGOs and the private sector in health care provision in Uganda by Kyaddondo, D. & Nangendo, F. (1997)

[31] BRAC Uganda. (2021). *COVID-19 Response Overview*. Kampala, Uganda.

Uganda runs youth-friendly corners where young people can access sexual health information confidentially and without judgment.[32]

By enhancing knowledge and awareness, NGOs promote the "acceptability" and "participation" dimensions of the right to health, empowering individuals to make informed decisions and assert their health rights.[33]

2.6 Community-Based Health Systems and Outreach Programs

A critical non-legal contribution of NGOs is the deployment and training of community health workers (CHWs). These CHWs serve as the first point of contact for health information, basic care, and referrals in rural and under-resourced areas. Programs like Living Goods Foundation's digitally enabled CHW model equip health workers with mobile technology to conduct home visits, monitor pregnancies, and manage childhood illnesses.[34]

This decentralized approach ensures continuity of care and culturally sensitive health services, which are often more effective in building trust within communities. Furthermore, the use of local personnel enhances community ownership and sustainability of health interventions.

[32] Reproductive Health Uganda, 2020

[33] Initiative for Social and Economic Rights (ISER). (2015). *The Right to Health in Uganda: A Handbook for Community Health Advocates*. Kampala, Uganda.

[34] Living Goods Foundation. (2020). *Annual Report*. Kampala, Uganda.

2.7 Emergency Response and Humanitarian Health Support

NGOs have demonstrated exceptional capacity in responding to public health emergencies and humanitarian crises. During outbreaks such as Ebola, cholera, and more recently, COVID-19, NGOs have been frontline responders distributing Personal Protective Equipment (PPE), setting up isolation centres, and disseminating prevention guidelines. During the COVID-19 pandemic, for example, NGOs such as World Vision and ActionAid Uganda supported vulnerable communities with food relief, hand-washing facilities, and psychosocial support.[35] These interventions were crucial in areas that remained inaccessible to formal government programs due to logistical constraints or funding shortages.

2.8 Advocacy, Accountability, and Citizen Empowerment

Though advocacy may be framed as legal in some contexts, it has strong non-legal dimensions, particularly in mobilising public opinion and influencing policy through grassroots activism and media engagement. NGOs like ISER and CEHURD conduct health budget analysis, publish scorecards, and organise public hearings to demand better resource allocation and quality service delivery.[36]

Through social audits, participatory health assessments, and media campaigns, NGOs hold duty bearers accountable by exposing inefficiencies, misallocations of health resources, and discriminatory practices within health service delivery. These participatory mechanisms not only empower local populations to monitor public service

[35] BRAC Uganda. (2021). *COVID-19 Response Overview*. Kampala, Uganda.
[36] Center for Health, Human Rights and Development (CEHURD). (2022). *Strategic Plan*. Kampala, Uganda.

delivery but also create a feedback loop that compels health authorities to take corrective action. NGOs like ISER have used community scorecards and public dialogues to present community grievances directly to policy makers, while CEHURD has utilised media advocacy to spotlight systemic health failures. These strategies are instrumental in amplifying the voices of marginalised groups such as women, persons with disabilities, and rural dwellers, who are often excluded from formal decision-making processes. By fostering greater inclusivity and accountability, NGOs promote a culture of transparency, responsiveness, and civic engagement, thereby reinforcing the broader principles of good governance and participatory democracy[37]. NGO's under go public accountability which is defined by Brautigam (1991:12) as 'the methods and practices whereby users of government and public services and those within public bureaucracies, ensure adequate levels of public service'. It embraces questions of efficiency and performance in the delivery of public services this is brought out by Micro-level accountability which is primarily concerned with the quality, cost, reliability and availability of public services, this is an area which greatly concerns NGO's in their relation with the local government institutions[38]. The rule of law in the perspective of NGO's serves to protect the rights of citizens in their efforts to enforce accountability from governments by limiting the scope for retribution on the part of state actors in response to what might be perceived as unwarranted interference in public affairs[39].

[37] Center for Health, Human Rights and Development (CEHURD), (2022). Strategic Plan. Kampala, Uganda.

[38] Andrew Clayton (1994) 'Governance, Democracy and Conditionality: What Role for NGO's.Pg.40

[39] Andrew Clayton (1994) 'Governance, Democracy and Conditionality: What Role for NGO's.Pg.41

2.9 Partnerships, Coordination, and Integration

NGOs often collaborate with multiple stakeholders including government ministries, international donors, private sector actors, and community-based organisations. These partnerships enhance resource mobilisation, policy coherence, and service reach. NGOs participate in national health forums such as the Health Policy Advisory Committee (HPAC) and the Health Development Partners' Group (HDPG), contributing to dialogue on national health priorities.

In addition to formal partnerships, many NGOs leverage informal networks and community linkages to enhance coordination and local engagement. These networks enable faster mobilisation of resources, dissemination of health information, and responsiveness during emergencies. For example, during the COVID-19 pandemic, partnerships between district health offices and NGOs like BRAC Uganda and World Vision enabled rapid response interventions in hard-to-reach communities, where public sector efforts were limited due to capacity constraints.[40] Moreover, NGOs play a bridging role between communities and policymakers by translating grassroots needs into policy-relevant language. Through participatory planning forums, community feedback mechanisms, and coalition-building efforts, NGOs ensure that marginalized voices are included in policy dialogues and national strategic plans. This intermediary role not only strengthens the legitimacy of public health planning but also fosters inclusive governance and more effective implementation of health programs.[41]

[40] Ibid
[41] Ministry of Health, Uganda. (2016). *Health Sector Development Plan 2015/16–2019/20*. Kampala, Uganda.

However, coordination challenges persist, particularly due to fragmented planning, weak data sharing, and competition for funding. Effective integration of NGO activities into district and national health plans remains inconsistent, limiting the potential for synergistic impact.[42]

2.10 Operational Challenges Faced by NGOs

Despite their pivotal role, NGOs face numerous operational hurdles. Over-reliance on donor funds makes NGOs vulnerable to shifting priorities and short funding cycles. The NGO Act imposes stringent registration and reporting requirements that can stifle smaller organisations. High turnover and limited incentives for health workers affect service continuity. Many NGOs operate in confined areas due to logistical and financial constraints. Advocacy-focused NGOs are often viewed with suspicion and may face restrictions, particularly during election periods or in politically sensitive districts.[43]

Though NGO's have played a fairly remarkable role in health service delivery, they have been sharply criticized as not existing for the common good and as being self-appointed trustees of the poor. NGO's have been found to rely on foreign funding for their programmes and lack the independence to challenge internal and external policies that may be detrimental to the poor and marginalised in society. Most NGO's in the third world countries do not question the invasion of SAP's in the productive and reproductive

[42] Ministry of Health, Uganda. (2016). *Health Sector Development Plan 2015/16–2019/20*. Kampala, Uganda.
[43] Initiative for Social and Economic Rights (ISER). (2015). *The Right to Health in Uganda: A Handbook for Community Health Advocates*. Kampala, Uganda.

spheres of women and yet these programmes exacerbate the unequal gender relations (Beneria & Feldman: 1992; Bandarage: 1997; Navtej: 2001)[44].

2.11 Monitoring, Evaluation, and Impact Measurement

Robust monitoring and evaluation (M&E) frameworks are crucial for assessing NGO impact, ensuring transparency, improving effectiveness, and building donor and community trust. Increasingly, NGOs in Uganda have adopted rights-based indicators and participatory M&E tools that not only assess health outcomes but also consider the qualitative aspects of community empowerment, changes in health-seeking behaviour, and responsiveness of health systems to local needs.[45] This shift from output-focused to rights-sensitive evaluation methods reflects a broader commitment to aligning interventions with the principles of the Human Rights-Based Approach (HRBA), including accountability, participation, and non-discrimination.

For example, the Uganda National Health Consumers' Organisation (UNHCO) has pioneered the use of community health scorecards as both diagnostic and accountability tools.[46] These scorecards facilitate structured dialogue between service users and health providers, fostering mutual understanding and enabling community members to voice their concerns in an organised manner (UNHCO, 2019). The data collected through this process informs not only local health facility planning but also national health policy recommendations.[47]

[44] Ben Kirombi Twinomugisha (2004) Protection of Rural Poor Women's Rights to maternal health care in Uganda: the case of Kashambya Sub-County, Kabale District.Pg. 58

[45] Uganda National Health Consumers' Organisation (UNHCO). (2019). *Community Scorecard Implementation Report*. Kampala, Uganda.
[46] Uganda National Health Consumers' Organisation (UNHCO). (2019). *Community Scorecard Implementation Report*. Kampala, Uganda.
[47] Uganda National Health Consumers Organisation. (2018). *The UNHCO SCAS Model FINAL*. Uganda National Health Consumers Organisation. https://unhco.or.ug/wp-content/uploads/downloads/2018/09/The-UNHCO-SCAS-Model-FINAL.pdf Pg.14

Furthermore, organisations such as CEHURD and Reproductive Health Uganda incorporate regular beneficiary feedback mechanisms, mid-term evaluations, and end-of-project reviews, which are critical in shaping responsive interventions. By gathering community perceptions of service delivery, cultural appropriateness, and satisfaction, NGOs generate actionable evidence to adjust their strategies and resource allocation.[48] International donors such as USAID and DFID increasingly require such participatory evaluation components as part of their funding criteria, encouraging a culture of learning and adaptation.

In addition, monitoring and evaluation framework (M&E) processes are no longer viewed as administrative obligations but as integral elements of quality improvement and strategic alignment in the NGO health sector. These systems help NGOs remain accountable not only to donors but also to the communities they serve, thereby enhancing legitimacy, sustainability, and the realisation of the right to health in a holistic and participatory manner.[49]

Flexibility in the face of Changing Needs: NGO's and Health Service Provision

The provision of health care services in Uganda to either the population at large or to particular groups of the population is through hospitals, health care and clinic-based delivery of health to the population of an area. These NGO's provide services that may or may not be acceptable to the government, but which are considered to be politically sensitive and impossible for the government to be directly associated with, examples

[48] Ibid fn. 26
[49] Reproductive Health Uganda. (2020). *Annual Impact Report*. Kampala, Uganda.

include refugee health care, or family planning with certain cultures. They offer health education programmes to the public[50].

2.12 Conclusion

NGOs play a transformative non-legal role in Uganda's health sector by addressing critical service delivery gaps, promoting health education, empowering communities and advocating for equity and accountability, NGO's substantially enable the progressive realisation of the right to health. Their actions are situational, frequently determined by local circumstances and intended to supplement the efforts of the state, yet their effectiveness is constrained by structural, regulatory and financial issues that need to be resolved through judicious policies and institutional changes. As the next chapter will show, integrating these non-legal contributions within a coherent legal and human rights framework as an essential for the sustainable health Justice in Uganda.

[50] The Role of NGO's in health service provision: A case study of Red Cross Busia District, Uganda by Agnes Mary Kemigisa, 2005. Pg.19

CHAPTER THREE

3.0 LEGAL FRAMEWORK ANALYSISING THE RIGHT TO HEALTH AND THE ROLE OF NGOS IN UGANDA.

3.1 Introduction

This chapter provides an in-depth doctrinal examination of the Ugandan legal frameworks governing the right to health, where the emphasis is on the facilitatory role of Non-Governmental Organizations (NGOs) as non-state actors in the health sector. This chapter looks at the intersection of International, Regional, and Domestic legal obligations informing the realization of rights to health and determines the degree to which these frameworks absorb and regulate NGOs in the healthcare system in Uganda. The analysis assesses the harmony between Uganda's domestic laws and its international obligations, identifying key gaps and suggesting the way forward for reform.

Through the incorporation of case law and drawing comparative lessons from progressed jurisdictions such as South Africa and India, the chapter presents a comprehensive assessment of Uganda's legal system. It underscores the strengths of judicial activism in filling legislative gaps and makes a compelling case for the revision of statutes to facilitate equitable, rights-based delivery of health care, especially through NGO initiatives.

3.2 International Legal Framework: Global Norms and State Responsibilities

The right to health is a founding concept in International human rights law, codified in several binding treaties and conventions to which Uganda is a signatory. These different treaties and conventions create a broad normative platform with legally

binding obligations for the state towards the realisation of the highest attainable standard of health for their populations.

They also set a standard and norm for the regulation of the non-state actors such as NGO's who have an equally important role in Uganda's health system. This section examines the key International Conventions, treaties and their relevance in Uganda and the obligations that they impose on the state and NGO's in enforcing health rights.

3.2.1 International Covenant on Economic, Social and Cultural Rights (ICESCR)

The International Covenant on Economic, Social and Cultural Rights (ICESCR), ratified by Uganda in 1987, is the primary global instrument enshrining the right to health. **Article 12 of the ICESCR** guarantees "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health," a provision that imposes progressive yet binding obligations on states. **The UN Committee on Economic, Social and Cultural Rights (CESCR) elaborated on this right in General Comment No.14**[51], introducing the AAAQ framework—Availability, Accessibility, Acceptability, and Quality as a practical benchmark for compliance.

Availability requires enough functioning health facilities, goods, and services, including those provided by NGOs, to meet population needs. Accessibility demands non-discriminatory access, encompassing physical, economic, and informational dimensions, particularly for marginalized groups like rural communities or low-income households. Acceptability ensures that health services respect cultural, ethical, and

[51] Ibid fn.1

gender norms, while Quality mandates scientifically and medically appropriate care delivered by trained professionals.

For Uganda, the ICESCR imposes a dual responsibility to directly provide health services and to regulate third-party providers, including NGOs, to ensure their interventions align with human rights standards. NGOs deliver approximately 30% of Uganda's healthcare services, particularly in underserved areas, making their regulation critical to fulfilling ICESCR obligations. The High Court's landmark ruling in **Center for Health, Human Rights and Development (CEHURD) v. Nakaseke District Local Government**[52] reflects this duty, where the court found that the failure to provide adequate maternal healthcare violated constitutional rights to life and dignity, an interpretation consistent with **Article 12 of the ICESCR**.[53] This case illustrates the judiciary's role in holding the state accountable for ensuring that NGO services meet the AAAQ criteria, particularly in addressing systemic gaps like understaffed health facilities or inadequate medical supplies.

3.2.2 Convention on the Rights of the Child (CRC)

The Convention on the Rights of the Child (CRC), ratified by Uganda in 1990, imposes specific obligations to ensure the health rights of children, a critical focus given that over 50% of Uganda's population is under the age of 18 years. **Article 24 of the CRC** mandates states to pursue the full realization of children's right to health, including access to primary healthcare, reduction of infant and child mortality, and provision of health education and information. In Uganda, where child health challenges such as

[52] Center for Health, Human Rights and Development (CEHURD) v. Nakaseke District Local Government Civil Suit No 111 of 2012

[53] International Convenant on Economic, Social and Cultural Rights (ICESCR)

malnutrition, malaria, and high infant mortality persist, the CRC provides a vital framework for prioritizing interventions. NGOs play a significant role in delivering child-focused health programs, for example immunization especially for the newly born babies, nutritional support since babies and young children need various nutrients for proper growth and school-based health education. However, their activities must be subject to rigorous state oversight to ensure compliance with CRC principles, such as non-discrimination and the best interests of the child. For example, NGO-led initiatives must avoid urban bias (this is where resources and development efforts are disproportionately focused on urban areas often compared to the rural areas) and ensure equitable access for children in remote or conflict-affected regions, aligning with Uganda's international commitments.

3.2.3 Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

The CEDAW was ratified by Uganda in 1985. It discusses gender-related health rights and under **Article 12** it calls for equal access to health services, including family planning, maternal health, and reproductive healthcare. The duty binds Uganda to have a responsibility of being gender-sensitive and tuned to structural hinderances towards women, such as high maternal mortality and low access to family planning medications for example contraception, birth control pills which are equally expensive to afford in rural regions.

The Constitutional Court's decision in **CEHURD & Others v. Attorney General**[54] this case identified the states inability to curb maternal mortality as a result of a violation of constitutional rights of equality under Article **21**[55] **of the Constitution of the Republic of Uganda 1995, as Amended and** also the right of dignity. This case is a pertinent in that it indicates the necessity for NGO's to incorporate into their programs a comprehensive reproductive health care system including prenatal care and safe delivery services under the state's regulation. The CEDAW emphasises on the issue of Non-discrimination under **Article 1 of the CEDAW** that defines non-discrimination and which necessitates that NGO's to set up avenues to overcome the cultural practices in a bid not only to make the services available but also make the services culturally responsive, that refuse women from accessing healthcare such as gender-based violence or early marriage, Female Genital Mutilation (FGM) which was evident in the case of **Tatu Kamau V Attorney General and 2 others**[56]**,** in this case the court held that there is no doubt that FGM was central to the culture in Kenya from medical evidence and they had no doubt about the long and short terms effects of FGM and that no one can be persuaded without their consent to undergo this harmful practice.

[54] Centre for Human Rights and Development (CEHURD) & Others v. Attorney General Constitutional Petition 16 of 2011

[55] The Constitution of the Republic of Uganda 1995, as Amended

[56] Tatu Kamau V Attorney General and 2 others; Equality Now and 9 others (Interested Parties); Katiba Institute and another (Amicus Curiae) [2021] eKLR

3.2.4 Convention on the Rights of Persons with Disabilities (CRPD)

The Convention on the Rights of Persons with Disabilities (CRPD), ratified by Uganda in 2008, affirms the right of persons with disabilities to equal access to health services under **Article 25 of the CRPD.** This comprises making health facilities and services physically accessible, culturally acceptable, and accommodating a range of needs, such as mobility, visual, or hearing impairments.

In Uganda, despite persons with disabilities experiencing enormous obstacles to care, like inaccessible clinics and the unavailability of sign language interpreters. The CRPD puts an onus on the regulation of the activities of NGOs to meet these necessities. For example, NGOs must provide ramps for mobile health clinics, braille versions of health education materials and also train and sign language interpreters to different facilities that take care of disabled people. Inadequate national standards and enforcement mechanisms for compliance with CRPD shows a significant shortage, especially with the dependence on NGOs to fill the gap in services in vulnerable areas.

3.2.5 Implications for NGO Regulation

The international legal system creates a particular standard for Uganda to fulfill health service requirements while overseeing external organizations that contribute to human rights development. Significant players in the Ugandan healthcare system, including NGOs, must implement their programs according to the AAAQ framework requirements and specific guidelines within the CRC, CEDAW, and CRPD. National laws face difficulties in creating necessary regulations since international bodies do not establish

specific guidelines for NGOs. The absence of official international guidelines for NGOs creates a dangerous regulatory vacuum, which leads to inconsistent service quality and unequal healthcare accessibility, particularly affecting rural and marginalized populations who receive care mainly from these organizations. To fulfill its international obligations, Uganda must establish proper supervision systems that enable transparent and participative NGO operations while being accountable to the government.

3.3 Domestic Legal Framework: Constitutional and Legislative Landscape

Uganda's internal legal system establishes the base to meet worldwide health rights responsibilities, yet it demonstrates fragmented implementation alongside obsolete laws and missing health rights language. Research examines both constitutional rules and essential laws and regulatory systems that control health rights while examining implications for NGO operations and difficulties in achieving worldwide standard compliance.

3.3.1 Constitutional Foundations

The Constitution of the Republic of Uganda 1995, as amended, serves as the supreme law but does not explicitly provide the right to health as a standalone, human right. Instead, it gives interpretive avenues through the National Objectives and Directive Principles of State Policy. **National Objective XX**[57] mandates the state to ensure the provision of medical services to all citizens, reflecting the commitment to universal healthcare. Although these objectives are not legally enforceable, they guide policy

[57] The Constitution of the Republic of Uganda, as Amended

formulation and judicial interpretation, offering a foundation for recognizing health-related rights.

Article 45 of the Constitution of the Republic of Uganda 1995, as Amended, further strengthens this framework by stipulating that the absence of a specific right in the Constitution does not preclude its recognition. This provision has enabled Courts to domesticate international health rights obligations, reading them into existing rights such as life and dignity. For example, in **CEHURD v. Nakaseke District Local Government**[58] the High Court invoked Constitutional rights to life and dignity, alongside international standards, to hold the state accountable for failing to provide maternal healthcare. Similarly, in **CEHURD & Others v. Attorney General**[59] the Constitutional Court linked maternal mortality to violations of equality and dignity, drawing on CEDAW and ICESCR principles. These rulings demonstrate a judicial willingness to bridge the Constitution's silence on health rights, but they further highlight the limitations of relying on judicial activism to compensate for legislative gaps. A Constitutional amendment explicitly recognizing the right to health could provide a more stable and enforceable framework, enhancing accountability for both the state and NGOs.

3.3.2 Legislative Framework

Uganda's legislative framework for health is characterized by a patchwork of outdated and sectoral laws that fall short of fully integrating international human rights standards, such as those articulated in the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Rights of the Child (CRC), and the

[58] Ibid fn. 2
[59] CEHURD & Others v. Attorney General Constitutional Petition No. 16 of 2011

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). These laws, primarily administrative or narrowly focused, fail to enshrine the right to health as an enforceable entitlement or align with the AAAQ framework, which requires health services to be available, accessible, acceptable, and of high quality. This fragmentation limits the state's ability to address modern health challenges, such as non-communicable diseases, mental health crises, and persistently high maternal mortality rates, while hindering effective regulation of non-governmental organizations (NGOs), which deliver approximately 30% of Uganda's healthcare services.

This analysis examines the major legislative frameworks Public Health Act and Children Act and the Domestic Violence Act, because they determine both health rights and NGO operational boundaries in the country.

3.3.2.1 Public Health Act Cap 310

The current state of the Public Health Act in Uganda since its establishment during the colonial era represents a vital legal framework that fails to meet present healthcare requirements and international human rights standards. The Act serves its original purpose through rules and regulations regarding sanitation and epidemic control, together with fundamental public health requirements, which include quarantine measures and water quality specifications. The Act fails to establish health as a fundamental human right in its framework and does not include the AAAQ model that would help create fair healthcare systems based on human rights. The lack of these components makes the Act unsuitable to handle contemporary health issues, which include escalating diabetes and hypertension cases, along with rising mental health

service requirements and the ongoing problem of maternal death, which affects 336 women in every 100,000 live births in Uganda.

The current law lacks specific provisions for controlling organizations which are not part of the government system especially Non-Government Organizations (NGOs) which play a vital role in the healthcare system of Uganda. The absence of official standards for health facilities managed by NGOs creates a situation where service quality and availability differ between urban and rural areas. The urban-based NGO clinics in Kampala provide advanced diagnostic services while the remote Karamoja region lacks essential supplies and properly trained staff. The state suffers from an inability to guarantee that NGO services follow the AAAQ standards for medical care quality and accessibility to underrepresented groups because of this regulatory void. The regulatory framework of the Act remains insufficient to manage NGO healthcare operations because it does not cover new developments such as telemedicine and health data privacy. The Public Health Act needs complete revision for the integration of human rights principles and establishment of specific non-state provider standards which will lead to fair and responsible health service delivery.

3.3.2.2 The Children Act

The Children Act[60]introduces important health-related protections for minors, particularly in cases of neglect, abuse, or abandonment, by mandating access to medical care in such circumstances. This reflects a commitment to safeguarding

[60] Children Act Cap.62

vulnerable children, a priority in Uganda where over 50% of the population is under 18 years of age and child health challenges like malnutrition, malaria, and high infant mortality remain prevalent. However, the Act is narrowly focused and sectoral, addressing health only in the context of specific violations rather than establishing broad, enforceable health entitlements for all children. This limited scope fails to integrate the obligations of **the Convention on the Rights of the Child (CRC), particularly Article 24,** which requires states to ensure universal access to primary healthcare, reduce infant and child mortality, and provide health education.

The Act's shortcomings significantly constrain its impact on NGO-led child health programs, which are critical in delivering services like immunization campaigns, nutritional support, and school-based health screenings. Many NGOs focus on targeted interventions, such as polio vaccination drives or deworming programs, but often fail to address systemic inequities, such as the lack of healthcare infrastructure in rural areas or barriers faced by children in conflict-affected regions like Northern Uganda. The absence of CRC aligned provisions in the Act means there is no legal mandate to ensure that NGO programs prioritize non-discrimination, community participation, or the best interests of the child, as required by international standards. For instance, urban-biased NGO initiatives may neglect remote communities, exacerbating disparities in child health outcomes. To strengthen its impact, the Children Act must be revised to incorporate CRC obligations, mandating comprehensive health rights for children and establishing standards for NGO interventions to ensure equitable and inclusive service delivery.

3.3.2.3 Domestic Violence Act

The Domestic Violence Act[61] represents a step toward addressing gender-based health needs by mandating medical attention for survivors of domestic violence, recognizing the physical and psychological toll of such abuse. This provision is particularly significant in Uganda, where gender-based violence affects approximately 51% of women, contributing to health issues like trauma, reproductive complications, and chronic pain. By requiring medical care for survivors, the Act aligns with the state's duty to protect vulnerable populations and reflects a partial commitment to gender-sensitive healthcare. However, its scope is narrowly confined to survivors of domestic violence, failing to address the broader requirements **of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) particularly Article 12,** which mandates equal access to comprehensive healthcare services, including family planning and maternal health.

The Act's sectoral nature limits its ability to guide NGO activities in delivering holistic health services for women, especially in rural areas where access to care is severely restricted. For example, while NGOs may provide trauma counseling or emergency medical care for domestic violence survivors, they often lack the resources or mandate to offer reproductive health services, such as prenatal care or contraception, which are critical for addressing Uganda's high maternal mortality rates. The Act's failure to integrate CEDAW's emphasis on non-discriminatory and equitable healthcare means there is no legal framework to ensure that NGO programs address systemic barriers,

[61] Domestic Violence Act Cap.123

such as cultural practices that limit women's access to healthcare or the shortage of female healthcare providers in rural clinics. To align with international standards, the Domestic Violence Act should be expanded to incorporate CEDAW's requirements, mandating comprehensive, gender-equitable health services and establishing guidelines for NGOs to prioritize women's health needs across all contexts.

3.3.3 Regulatory Framework for Non- Governmental Organisations (NGOs)

The NGO Act[62]governs the operations of non-governmental organizations, requiring them to register with the NGO Bureau and comply with government oversight. While the Act acknowledges NGOs' contributions to service delivery, it is silent on integrating human rights principles into their activities. It does not mandate alignment with Uganda's obligations under the ICESCR, CRC, CEDAW, or CRPD, nor does it establish mechanisms to ensure transparency, participation, or accountability in NGO health services. This regulatory void is particularly concerning, given that NGOs provide nearly 30% of Uganda's healthcare services, often in areas where government facilities are absent or under-resourced in districts like Apac and Kabale[63] Without clear standards, NGO operated clinics may prioritize donor-driven agendas, such as HIV/AIDS programs, over holistic primary healthcare, exacerbating inequities in access. The absence of a human rights-based regulatory framework risks inconsistent service quality and undermines Uganda's ability to fulfil its international commitments.

[62] Non- Governmental Organisation Act Cap.109

[63] The Role of NGOs and the private sector in health care provision in Uganda by Kyaddondo, D. & Nangendo, F. (1997) Pg.18

3.4 Comparative Legal Perspectives: Lessons from Global Models

A comparative analysis with jurisdictions like South Africa and India highlights the limitations of Uganda's legal framework and offers actionable insights for reform. These countries have robust Constitutional and Judicial mechanisms that elevate the right to health to an enforceable entitlement, providing models for strengthening Uganda's approach to health rights and NGO regulation.

3.4.1 South Africa's Constitutional Model

The South African Constitution (1996) explicitly guarantees the right to access healthcare services under **Section 27,** imposing immediate and positive obligations on the state. This Constitutional entrenchment has enabled robust judicial enforcement, as seen in the landmark case of **Minister of Health and 8 others v Treatment Action Campaign and 2 others**[64] The Constitutional Court ordered the government to remove restrictions on access to anti-retroviral drugs for HIV/AIDS treatment, affirming that health rights are justiciable and require proactive state action. This ruling not only expanded access to life-saving medication but also set a precedent for regulating non-state actors, including NGOs, to ensure equitable service delivery. South Africa's model demonstrates the transformative potential of Constitutional recognition, offering Uganda a blueprint for amending its Constitution to explicitly enshrine the right to health. Such a reform could enhance accountability for both the state and NGOs, ensuring that health services meet the needs of vulnerable populations.

[64] Minister of Health and 8 others v Treatment Action Campaign and 2 others Constitutional court of South Africa Case CCT 8/02

3.4.2 India's Judicial Activism

In India, the Supreme Court has interpreted **Article 21 of the Constitution,** which guarantees the right to life, to include the right to health, creating a dynamic framework for enforcement. In **Paschim Banga Khet Mazdoor Samity v. State of West Bengal and another,**[65] the Court mandated the provision of timely and adequate medical services, particularly for the poor and vulnerable, emphasizing the state's duty to ensure accessible healthcare. This judicial approach has driven systemic reforms, such as improvements in public health infrastructure and regulation of private providers. India's experience illustrates how courts can expand the scope of existing rights to address health inequities, offering lessons for Ugandan courts grappling with similar challenges. By adopting a similar interpretive approach, Uganda could leverage its Constitution's flexibility to recognize health rights, while legislative reforms could provide a clearer statutory basis for enforcement.

3.4.3 Implications for Uganda

Health rights enforcement becomes clear through the legal systems of South Africa and India, which highlight the need for Constitutional recognition alongside judicial protection and regulatory controls. The explicit Constitutional guarantees of South Africa and the judiciary-led health rights approach of India conflict with Uganda's approach that depends on non-binding policy objectives and scattered laws. The country needs to start working on a Constitutional amendment which will protect health rights and implement Public Health Act and NGO Act reforms, and integrate human

[65] Paschim Banga Khet Mazdoor Samity v. State of West Bengal and another (1996) AIR SC 2426/ (1996) 4 SCC 37

rights standards into the NGO Act Cap 109. The state will develop enhanced NGO regulation through these modifications to ensure that their operations are both equal and follow the AAAQ framework. Independent oversight bodies, including a health rights ombudsman, should be created to improve accountability through a system based on the South African Health Ombud model.

3.5 Conclusion

Uganda established powerful international commitments for healthcare rights protection, yet its internal system remains fragmented and obsolete. The ICESCR, CRC, CEDAW, and CRPD treaties establish strong normative standards which mandate equal healthcare service delivery. The 1995 Constitution combined with the Public Health Act prevents the state from fully executing its responsibilities because the constitution does not directly mention health rights and the statutes remain outdated. The regulatory framework of NGO Act Cap. 109 does not include human rights standards which results in a regulatory void for the 30% of healthcare services delivered by NGOs.

The judicial system through cases such as **CEHURD v. Nakaseke District Local Government and CEHURD & Others v. Attorney General** reveals how courts can bridge gaps between laws, but judicial activism depends on legislative modifications for long-term sustainability. The transformational power of Constitutional entrenchment together with judicial enforcement according to South Africa and India provides a way forward for Uganda. Uganda needs to make substantial changes to its legal framework to meet international requirements which involve adjusting the Public Health Act to incorporate the AAAQ framework and modifying the NGO Act to enforce human rights

standards while considering constitutional amendments which would cement the right to health. The proposed reforms will establish a rights-based system for NGOs to deliver healthcare services which will be both equitable and transparent. A health governance system that upholds human rights principles stands as an essential requirement to solve Uganda's broad health system challenges and meet worldwide health commitments.

CHAPTER FOUR

4.0 FINDINGS, ANALYSIS, RECOMMENDATIONS, AND CONCLUSION

4.1 Introduction

This section combines all research findings from the study to analyze the way Non-Governmental Organisations (NGOs) participate in health rights implementation within Uganda. Non-legal perspectives and doctrinal analysis from the previous sections establish an assessment of international legal requirements along with domestic operational constraints and NGO normative functions in health service delivery. The final section provides evidence-based proposals which seek to improve Ugandan legal and policy instruments through effective integration of NGO contributions into a rights-oriented health system.

4.2 Summary and Analysis of Key Findings

Researchers discovered that non-governmental organizations play an essential role in the health sector of Uganda, especially in rural and underserved areas where state services are not available or insufficient. Non-governmental organizations perform essential functions through direct service provision and emergency response as well as community outreach and health education, while simultaneously conducting advocacy work and strengthening healthcare systems. Their interventions have often bridged critical gaps in government capacity, making them vital partners in advancing health outcomes. However, the lack of a harmonised legal framework to guide and regulate their operations has led to fragmented and inconsistent approaches, undermining both effectiveness and accountability.

While Uganda has ratified several international and regional instruments that articulate a robust right to health, including the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Rights of the Child (CRC), and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), these commitments have not been sufficiently domesticated. The Constitution of the Republic of Uganda 1995, as amended does not explicitly recognise the right to health as a justiciable entitlement. Although National Objective XX of the of the National Objectives and Directive Principles of State Policy[66] requires the state to ensure the provision of basic medical services which affirms the state's responsibility to ensure medical services, its non-enforceable nature limits its practical application.

Courts have occasionally interpreted other rights, such as the rights to life and dignity, to implicitly include health-related obligations, but this judicial approach lacks the consistency and authority of a formally recognised Constitutional right. Additionally, **Article 45[67]provides** interpretive room for recognising unenumerated rights, especially those derived from international obligations.

At the statutory level, Uganda's Public Health Act[68] remains outdated and ill-equipped to address modern health challenges or regulate non-state actors effectively. The NGO Act[69], while acknowledging the role of NGOs in service provision, is silent on the requirement for alignment with human rights principles such as those embedded in the Human Rights-Based Approach (HRBA) and the AAAQ framework Availability,

[66] The Constitution of the Republic of Uganda 1995, as Amended

[67] Ibid fn.1

[68] Public health Act Cap.310

[69] Non- Governmental Act Cap. 109

Accessibility, Acceptability, and Quality. Consequently, NGOs operate in a regulatory vacuum where service quality, equity, participation, and transparency are not consistently monitored or enforced.

Furthermore, another major finding is that NGOs face significant institutional and operational challenges. These include over-dependence on donor funding, staff shortages, logistical constraints, and bureaucratic hurdles related to registration and compliance. Some advocacy-oriented NGOs also experience political hostility, particularly when they question government accountability or highlight systemic failures. The lack of a formal mechanism for integrating NGOs into national and district health planning processes has further complicated coordination efforts and led to duplication, resource wastage, and uneven service coverage.

Comparative analysis reveals that other jurisdictions, particularly South Africa and India, have made significant progress by recognising the right to health as a constitutional and justiciable right. In South Africa, for instance, the Constitutional Court's decision in **Minister of Health and 8 others v Treatment Action Campaign and 2 others Constitutional court of South Africa.**[70] reaffirmed the enforceability of health rights, compelling the state to expand access to life-saving treatment. Similarly, India's judiciary has interpreted the right to life to include the right to health in the case of Paschim Banga Khet Mazdoor Samity v. State of West Bengal and another.[71] The Court mandated the provision of timely and adequate medical services, particularly for the poor and vulnerable, emphasizing the state's duty to ensure accessible healthcare. This

[70] Minister of Health and 8 others v Treatment Action Campaign and 2 others Constitutional court of South Africa Case CCT 8/02
[71] Paschim Banga Khet Mazdoor Samity v. State of West Bengal and another (1996) AIR SC 2426/ (1996) 4 SCC 37

judicial approach has driven systemic reforms, such as improvements in public health infrastructure and regulation of private providers thereby enabling courts to hold the state accountable for failing to provide adequate healthcare. These examples underscore the importance of embedding health rights within Constitutional and statutory law and demonstrate the potential of legal reform to enhance NGO accountability and strengthen public health systems.

In Uganda's context, the gap between normative commitments and operational realities remains a persistent challenge. The legal framework is characterised by fragmentation, outdated statutes, and a failure to mainstream human rights principles into health governance. This institutional weakness has allowed NGOs to operate without adequate legal safeguards, thereby limiting the consistency and quality of their contributions to the realisation of the right to health.

4.3 Recommendations

The research presents a series of key recommendations to improve NGO involvement in promoting health rights in Uganda using the obtained information and adopted research framework.

I recommend, that Uganda should modify its Constitution by officially recognising and also incorporate various Articles in Constitution that provide for the right to health, as an essential and enforceable legal rights. The implementation of such a law would provide both judicial and legislative enforcement mechanisms, which would bring domestic statutes into alignment with Uganda's global treaty obligations.

Through this provision, people and groups would gain the ability to demand for the highest attainable standard of health entitlements in courts while enhancing the legal standing of complaints filed against violators.

The Public Health Act Cap 310 and NGO Act Cap. 109 require urgent amendments in their provisions according to both current societal conditions and human rights standards. The recommended changes should make it compulsory for NGOs to implement Human Rights-Based Approach (HRBA) within their service delivery systems and should ensure that different roles are given to NGO's and not to various official government offices, departments or Ministries

Non-governmental organizations should comply with the AAAQ standard and integrate rights-based monitoring and evaluation tools into their operations according to legal requirements. The updated legislation needs to establish binding protocols that ensure necessary collaboration between NGOs and Government health facilities across all administrative levels.

I recommend that NGO's should ensure expansion of public legal education, this means the educational process that provides knowledge and skills related to various aspects of health. This should become the focus for establishing community understanding regarding health rights. This should be done through raising awareness about health issues that's to say that when people are well informed about the dangers of smoking unhealthy diets and lack of exercise it might cause serious long-term effects, promoting preventive healthcare, empowering various communities, addressing health

inequalities and improving mental health awareness which is done through monitoring and evaluation of the projects.

I recommend that Legal education must become an essential element within NGO's programming especially for the benefit of underprivileged rural populations. When citizens grasp their health rights, they enable participatory governance while establishing accountability frameworks for both state entities and non-state groups.

The learning process adopted by Uganda needs to follow international best practices as a recommendation, the health sector transformation through legal recognition and judicial activism receives guidance from South Africa and India among other jurisdictions. Uganda can learn from these various teachings by creating legal empowerment for civil society organizations and integrating them structurally while enforcing unified accountability standards.

I recommend that Uganda should carefully examine the National laws and Statute books of the countries where NGO's are active in order to examine official positions on economic and social rights such as the right to health of specific countries.

4.4 Conclusion

This study concludes that although NGOs have a central role to play in Uganda's health system, most of their impact is now constrained by structural and regulatory problems. The lack of a constitutionally enshrined right to health and scarce effective legal regimes with institutional coordination creates a situation where NGOs are operating in an unregulated environment to the detriment of both effectiveness and compliance with rights. International obligations provide Uganda with a normative basis for health

rights, but to a large extent, health rights have not been domesticated in the state. NGOs cannot replace the State, where, in good faith, many of them have rendered excellent services in localised set-ups.

Accordingly, Uganda ought to move beyond informal and donor-driven models of health governance. A sustainable health system, therefore, calls for a legally entrenched process that places the right to health at the core of national policy while providing an environment wherein all actors, including NGOs, operate transparently, coordinate their actions, and uphold respect for human rights. Reform is needed, not only to meet Uganda's Constitutional and International obligations but also to advance health equity, dignity, and justice for all citizens.

4.5 Final thought.

This dissertation has endeavored to query the role of NGO's within the achievement of the right to health within Uganda from both human rights and doctrinal perspectives. The question progressed to disclose a complex interaction amongst non-state action, law, and state obligation, which has uncovered both the strong potentials of NGO's and the pervasive institutional shortcomings which disenabled them.

The other concern is the inadequacy of existing regulatory and legislative structures for NGO's and public health activity. The Public Health Act remains antiquated, missing normative terminology and institutional shortcomings which disenabled them.

The research identifies a pervasive paradox at the heart of Uganda's health system. NGO's are crucial to health programming and provision, but they are operating within

an environment of institutional instability, policy unclearness, and uncertainty about the law.

Normatively, Uganda is obligated by the right to health under a number of International and Regional human rights instruments, including the ICESCR, CRC, CEDAW, and the African Charter on Human and People's Rights.

All the above instruments reaffirm the right to the highest achievable standard of health and invoke the necessity for control and coordination by the state over third-party actors, i.e., most importantly, non-governmental organizations. Despite the challenges the study's conclusion is that NGO's still retain a changing capacity of healthcare accessibility, and most importantly the poor and excluded groups in rural areas and in accordance with human rights principles.

At the national level, Uganda has still to implement the above commitments. The absence of an express provision for the right to health as an enforceable right under the Constitution is a gap which makes enforceability and access to remedy improbable for victims whose rights have been infringed and enforcement capacity to steer a modern, equitable, and human rights-based health system.

The NGO Act, acknowledging the activities of non-state actors, makes no provision for the legal requirement for compliance with human principles, or for organizational planning with public health institutions on an integrated basis. This regulatory absence has fostered unregulated NGO work which though frequently effective, is not necessarily coherent and human rights oriented.

These normative shortcomings are further combined by the realities of operations, donor reliance, personnel shortages, logistical issues, and, in certain cases, political security are issues that concern the NGOs. The fact that they are barred from being involved in national planning frameworks causes them to replicate duplication and overall system vulnerability. In addition, the fact that there are no strict monitoring and evaluation norms, and more specifically those tied to human rights norms, undermines transparency and impact analysis of far to reach areas.

Their visibility, legitimacy and programmatic diversity make them well placed to react quickly to emerging health crises and pent-up demand. Responsiveness and innovativeness cannot be set aside. Rather, it must be harnessed within a more effective policy and legislative framework that clarifies roles, enhances accountability and secures sustainability.

The wider implication of this study is that actualization of the right to health under Ugandan conditions cannot be left to the ad-hoc initiatives of the NGO's alone. Health as a public good and universal human right must be enshrined through law and guaranteed by the full apparatus of state obligation, relying over the long term on non-state actors to fill gaps within the system is symptomatic of structural fault lines which can be addressed only through an elemental shift within legislation policy and institutional reform. These include enshrining the right to health in the constitution, mordernising antiquated pieces of legislation, improving mechanisms for enforcing accountability and institutionalising participatory and rights-based programs at every level of health governance.

Furthermore, the research also witnesses the necessity for grassroots level legal literacy and empowerment. Without an empowered and capacitated citizenry that can demand its rights and hold duty-bearers to account and reform which can be symbolic. NGO's must thus expand from provision of services to continued community organisation, legal empowerment, and participatory governance. The state must similarly transcend tokenistic consultation and also create real spaces for civil society participation in decision-making and scrutiny.

Above all, and most significantly, the comparative experience between India and South Africa proves the transformative promise of judicial and Constitutional enforcement of the health rights. Each system has proven that, when health is a policy objective and an enforceable right under law, it becomes a powerful instrument for social Justice and equity. This can be Uganda's path, but not through unthinking transplantation of models from one place to another, but through a judicious use of the best international practice to suit Ugandan socio-political and legal actuality.

In conclusion, Uganda's right to health stands at a crossroads. Continued reliance on NGO's, coupled with the absence of accompanying legislative reform, threatens to deeply institutionalise inequality, seal fragmentation and erode state accountability. Uganda must have a paradigm change, one which recognises health as a right, enshrines this within law, and pulls NGO activity within an organised, transparent and accountable system of governance. Then and only then, can we expect the country to move towards the progressive realisation of the right to health for all its people.

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