AN ANALYSIS ON THE BARRIERS TO HEALTH CARE ACCESS IN UGANDA

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DECLARATION

I Kobusinge Bridget do hereby declare that this dissertation entitled 'an analysis on the barriers to health care access in Uganda is my original work and that it has never been submitted to any other University or institution of higher learning for any academic award.

Signed ……..Date.……..

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DEDICATION

I truly and sincerely dedicate this work to the almighty God who has given me life and the strength to finish my mission; I dedicate myself fully to him.

I dedicate this dissertation to my amazing family in appreciation of their unwavering support throughout my academic career.

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Contents

ACRONYMS

WHO	World Health Organization
MHS	Military Health System
UDHR	Uganda Declaration of Human Rights
WH	World Bank
PHC	Public Health Care
NODPSP	National Objectives Directive Principle of the State Policy
ACHPR	The African Charter on Human and Peoples Rights.
MDGs	The Millennium Development Goals
PWD	Persons with Disabilities
SDGs	Sustainable Development Goals
ICESCR	International Conventional on Economic Social and Cultural Rights
UN	United Nations
NGOs	Non-Governmental Organizations

UDHR Universal Declaration of Human Rights

CHR Commission on Human Rights

ESC Economic and Social Council

CEDAW Convention on Elimination of all forms of Discrimination Against Women

CRC Convention on the Rights of the Child

EAC East African Community

NDP National Development Plan

ABSTRACT

This study is about analyzing the barriers to healthcare access in Uganda and it was guided by four objectives namely; To analyze the international, regional and national legal and policy framework on the on the right to access health care services in Uganda, To assess the financial barriers that hinder healthcare access, To evaluate the infrastructure and resource gaps in healthcare facilities, To identify the challenges in the implementation of constitutional provisions on the right to access health care services in Uganda.

Analyzing the barriers to healthcare access in Uganda is crucial for understanding the challenges faced by individuals in obtaining medical services. The abstract would delve into factors such as limited healthcare infrastructure, inadequate healthcare funding, shortage of healthcare professionals, and lack of awareness about healthcare services. By examining these barriers, we can identify potential solutions to improve healthcare access and delivery in Uganda

CHAPTER 1

1. 1 Introduction

Health is wealth, it is the biggest asset we need every day to meet our goals. More so enhancing the well-being of a nation's citizens is a global imperative as well as one of the Millennium development Goals (MDGs). In light of this, Uganda has implemented a number of health sector reforms and policies since the late 1980s with the goal of enhancing the sector's effectiveness and performance as well as the population's overall health. Uganda's health services and overall health status have not significantly changed in spite of these policies and reforms, which include a general decentralization of administration. In actuality, Uganda's health care system and related metrics have stayed poor.[1]

For instance, compared to the circumstances five years prior, statistics from the Uganda Demographic Health Survey of 2000–2001 indicate additional declines in health status and health service delivery. A case in point, the Maternal Mortality Ratio (MMR) was estimated in 2006 at 435 maternal deaths per 100 000 live births (Uganda Bureau of Statistics and Macro International Inc. 2007), showing little progress

[1] Dr. Nabukeera, M. (Mar-Apr. 2016) *challenges and barriers to the health service delivery system in Uganda.* Available from: https://www.iosrjournals.org/iosr-jnhs/papers/vol5-issue2/Version-5/D0502053038.pdf. [accessed 22 April 2014]

towards the government‘s own goal of reducing maternal mortality from 500 to 300 between 2001 and 2008[2]. Considering these developments, an overview is necessary to analyze the current status as well as past trends regarding health service delivery in Uganda with an object to identify the various challenges and barriers in the system and possibly come up with recommendations[3].

Healthcare access is still a major issue in developing nations, particularly in Africa's sub-Saharan areas. Western health models and beliefs have shaped the historical evolution of health services; these models and beliefs have rarely taken into account the ways in which local people seek guidance or explain or comprehend ailments. Numerous variables, including a lack of transportation infrastructure, geographical variances, rural-urban inequities, and cultural barriers to access, limit healthcare access in Uganda[4].

These problems are further exacerbated by famine, insurgencies, and a lack of financial resources. One of the main goals of this research was to determine whether the barriers affecting Uganda’s access to healthcare facilities and services were political or cultural in nature. Additionally, this research will provide insight. This study will also highlight any gaps in healthcare services that exist in the area and

[2] Ibid note 1
[3]Supra note 1.
[4]Syeda, S. [2019] *Assessing Barriers to Healthcare Access in Oyam District, Uganda.* Available from: https://www.proquest.com/openview/3bf2449044714dbceaccfec022ce17a2/1?pq-origsite=gscholar&cbl=18750&diss=y [Accessed 22 April 2024].

could be brought on by the LRA insurgency, the political climate, or existing cultural attitudes[5].

The study's findings offer a thorough analysis of the obstacles preventing people in Uganda from accessing healthcare facilities and services. The following areas have been highlighted as being important to focus on which include future actions and initiatives that would improve the standard and accessibility of healthcare services for the people of Uganda : transportation infrastructure, sufficient staff with proper training, medication, supplies, and equipment, community health education, and the financial[6]

1.2 Background

The right to health is a fundamental part of our human rights and of our understanding of a life indignity. The right to the enjoyment of the highest attainable standard of physical and mental health, to give it its full name, is not new. Internationally, it was first articulated in the 1946 Constitution of the World Health Organization (WHO), whose preamble **defines health** as ‘’a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’’[7].

[5] Ibid note 4
[6] Ibid note 3.
[7] The *Constitution of the World Health Organization* was adopted by the international Health Conference held in New York 19 June to 22 July 1946 available from: https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf [Accessed 22 April 2024]

The preamble goes on to say that "every human being has the fundamental right to the enjoyment of the best possible standard of health, regardless of race, religion, political belief, economic situation, or social status"[8]. Several global health initiatives have continuously advocated for health equality for all, especially for the vulnerable members in the communities. The World Health Organization has been on the forefront advocating for equitable access to health care and the promotion of health equality.

Under the national laws, the right to health is not explicitly provided for in the Bill of Rights of the constitution of the republic of Uganda. However it contains a number of provisions in NODPSP of the constitution with the bearing on health. The state under the constitution gives us articles where a right to health is provided. Where under objective XX talks about medical services, and it states that the state shall take all practical measures to ensure the provision of basic medical services to the population. Objective XXI talks about clean and safe water, XXII talks about food security and nutrition[9]

Also a number articles in the constitution of Uganda like article 39 which talks about a right to a clean and healthy environment and many other articles[10]. The constitution contains a number of human rights and freedoms, which are critical for the protection of the right to health, given the interdependence, indivisibility and interrelationship

[8]Ibid note 5.
[9] The National Objectives and Directive principles of state policy set out in 1995 constitution. The constitution was promulgated on the 8th day of October, 1995 by the Constituent Assembly replacing the 1967 Constitution.
[10] The constitution of the republic of Uganda, 1995 as amended. The constitution was promulgated on the 8th day of October, 1995 by the Constituent Assembly replacing the 1967 Constitution.

of human rights. These include equality and freedom from discrimination Article 21 of the right to life, article 22 respects for human dignity and prevention from torture or cruel, inhuman or degrading treatment or punishment, article 30 rights of women and many others[11].

In light of the aforementioned provisions and interpretations, where article 20 of the constitution provides for respect, upholding, and promotion of the rights enshrined in the constitution, such obligation encompasses the right to health[12].

The Persons with Disabilities Act, 2019[13] particularly seeks to offer legal protection to persons with disabilities in light of affirmative action reflected in Article 32 of the Uganda 1995 constitution. In relation to health care, the Act provides for the right to health and accessibility. On the right to health, it entails; the provision for equal enjoyment of rights of people with disabilities with other members of society and obligates government to ensure that sign language is introduced in the curriculum for medical personnel, interpreters are included in hospital organizational structure, and labels on medicine are pre-brailed. The Act further mandates government to promote social health services required by persons with disabilities[14].

The 1948 Universal Declaration of Human Rights also mentions health as part of the right to an adequate standard of living Article 25(1) stipulates that everyone has the right to an adequate standard of living including the right to health, which includes

[11] Ibid note 8.
[12] Supra note 8
[13] *The Persons with Disabilities Act* 2020, (authenticated on 19th September, 2019). Available from: https://ulii.org/akn/ug/act/2020/3/eng@2020-02-14 [accessed on 22nd march 2024]
[14] Ibid note 11

housing, food, and medical care with necessary social services and the right to security in the event of sickness, disability, old age and many others[15].

The right to the highest attainable standard of health is a human right recognized in international human rights law. Everyone has the right to the best possible level of physical and mental health, which is recognized by the International Covenant on Economic, Social, and Cultural Rights, which is widely regarded as the primary tool for defending the right to health. It is noteworthy that the Covenant accords equal weight to bodily and mental health, both of which have too frequently been disregarded[16].

The African (Banjul) Charter on Human and Peoples Rights (ACHPR)[17] ensures the right to the finest possible state of mental and physical well-being. State parties are required to take the appropriate actions to safeguard the health of their citizens and make sure they get medical care when they are ill[18]. In a number of decisions, the African Commission has also elaborated on the normative framework of the right to health under the ACHPR.

[15] *Universal Declaration of Human Rights*. Available from: https://www.un.org/en/about-us/universal-declaration-of-human-rights [Accessed 22 April 2024]

[16] ibid note 13.
[17] *African [Banjul] Charter on Human and People's Rights* (June 27, 1981). Available from: http://hrlibrary.umn.edu/instree/z1afchar.htm [Accessed on 22 April 2024]
[18] ibid note 15.

For example, in the case for Free Legal Assistance Group and others v Zaire[19], the African commission stated that the failure by the Government to provide basic services, such as safe drinking water and electricity, and shortage of medicine amounts to a violation of the right to health under ACHPR. In the Sudan Human Rights Organization and another v Sudan[20], the African commission stated that the right to health extends not only to timely and appropriate health care services but also to the underlying determinants of health such as access to safe and portable water, an adequate supply of safe food and nutrition.

As per article number 38 of 2021, the percentage of Ugandans within a one-hour walking distance of the nearest health center II is 71.73%, increasing to 90.57% through bicycles. Bicycles increased one-hour access to the nearest health center III from 53.05 to 80.57%, increasing access to the tiered integrated national laboratory system by 27.52 percentage points. Significant clusters of low health center access were associated with areas of high poverty and urbancity[21].

A strong direct relationship between travel time to health center and poverty exists at all health center levels. Strong disparities between urban and rural populations

[19] *Free legal Assistance Group and others v Zaire No.25/89 (1995).* Available from: https://www.globalhealthrights.org/wp-content/uploads/2014/07/Free-Legal-Assistance-Group-and-Others-v.-Zaire.pdf [Accessed 22 April 2024].

[20] *Sudan Human Rights Organization and Centre on Housing Rights and Evictions (COHRE) v Sudan* (November 2010). Available from: https://www.ohchr.org/sites/default/files/lib-docs/HRBodies/UPR/Documents/Session11/SD/COHRE_TheCentreonHousingRightsandEvictions-eng.pdf [Accessed 22 April 2024]

[21] Nicholas, D. [published 18 January 2021]. *Exploring Country Wide Equitable Government Health Care Facility Access in Uganda* .Available from: https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-020-01371-5 [Accessed 22 April 2024].

exist, with rural poor residents facing disproportionately long travel time to health center compared to wealthier urban residents[22].

According to the World Report on Disability (2011)[23] by World Health Organization (WHO) and The World Bank (WB), it is estimated that one billion people are living with some form of disability and of these 200 million are children. Most importantly, the report notes that people with disabilities are among the poorest of the poor, and do not have equal opportunities and equal access regarding employment, health and education. Consequently their rights are violated and this stands as one of the barriers to access healthcare services because in most hospitals you find that the disabled people are not catered for in terms of infrastructure[24]

Furthermore, the 2014 Uganda Population and Housing Census Report states that 12.4% of people are classified as persons with disabilities. When the data is broken down by age, it becomes clear that senior people with disabilities (65 years and above) make up 2.1% of the population, while children with disabilities (17 years and under) make up 2.9%, teens with disabilities (18–30 years) are 2%, and adults with disabilities (31-64) are 5.5%.

Gender-specific analysis shows that women experience disability at a higher rate (13.7%) than men do (11%). Additionally, the rate of disability prevalence is higher in urban regions (15%) than it is in rural ones (12%). The most common type of handicap

[22] ibid note 19.
[23] World Report on Disability 2011 (World Health Organization 2011). https://www.ncbi.nlm.nih.gov/books/NBK304079/ [accessed 22 April 2024]
[24] Ibid note 21 .

is visual impairments (6%), which are followed by mental disabilities (5%), physical impairments (4%), and hearing issues (3%)[25].

Persons with disabilities encounter a variety of barriers; including discrimination, negative societal attitudes, an inaccessible physical environment, information and communication technology, and insensitive disability-friendly regulatory frameworks. These factors lead to unequal access to services such as education, employment, healthcare, transportation, political engagement, and justice in communities. Ugandans with disabilities still have many obstacles when it comes to accessibility. Most public buildings are not entirely accessible to people with impairments, restricting their participation and benefit from service delivery 3[26].

The private sector has been hesitant to make the required changes to improve accessibility. Because most people with disabilities reside in rural areas, their ability to travel around and participate in family and community life is limited by physical infrastructure, road networks, and public transportation systems. Access and usage of health services by people with disabilities are hindered by the lack of proper physical infrastructure such as ramps, wheelchairs, and disability-friendly sanitation facilities in hospitals.

[25] *Nation Union of Disabled Persons of Uganda Joint Submission on Universal Periodic Review for Uganda*. Available on: https://www.ohchr.org/sites/default/files/lib-docs/HRBodies/UPR/Documents/session12/UG/JS5-JointSubmission5-eng.pdf [Accessed on 23 April 2024]

[26] CHRISTIANA, K. (5th August 2023). 5 *Barriers That Impact People with Disabilities*. Available from: https://lifespan.ku.edu/be-aware-5-barriers-impact-people-disabilities [accessed 23 April 2025]

And by the Alma Atta "Health for all" declaration of 1978[27], which expresses the need by all governments to protect and promote the health of its entire people through Primary Health Care (PHC)[28].

Uganda as a country has made significant progress in improving healthcare services over the years. However, there are still various challenges that hinder access to healthcare for many individuals and these challenges can be influenced by factors such as social economic status, geographical location, cultural beliefs, infrastructure limitation, and government policies hence by looking at this research topic, we can gain a better understanding of the specific circumstances that contribute to these barriers and work towards addressing them effectively.

1.3 Statement of the problem

The problem to be addressed in this proposal is an analysis on the barriers to health care services in Uganda and looking for a way forward to solve these barriers.

Like during the 1970s and 1980s Uganda went through a period of political and economic upheaval, resulting in the breakdown of main services and in the health sector it was characterized by general system failure. Funding was grossly insufficient

[27] Article by the World Health Organization [No date]. *WHO called to return to the Declaration of Alma-Ata*. Available from: https://www.who.int/teams/social-determinants-of-health/declaration-of-alma-ata [accessed on 23 April 2024]
[28] Ibid note 25

leading to problems of merge and salaries for health workers, permanent shortages of medicines and supplies, and dilapidated infrastructure[29].

And the reality today is that Uganda has around 6,940 health facilities of which 45% are government-owned, 15% are private not-for-profit, and 40% are private for profit and in 2019, the health worker population ratio was 1.87 per 1,000 population, which is still lower than the WHO ratio of 2.5 per 1,000 population and they go on to say that although progress has been made in achieving health related targets, several issues still require attention[30].

There is need for a comprehensive redefinition of health service delivery, enhanced investment in health infrastructure, training and retaining healthcare professionals, ensuring the availability of necessary medical supplies, and strengthening healthcare systems at all levels because shortage of healthcare professionals, medical equipment, and essential medicines can hinder access to quality healthcare and addressing these gaps requires investments in healthcare with a focus on reducing inequalities; and establishment of a national health insurance scheme.

1.4 General objective of the study

The general purpose of the study is to analyze the barriers to healthcare services in some parts of Uganda.

[29] Uganda Bush War [no date]. Available from: https://en.wikipedia.org/wiki/Ugandan_Bush_War#Names [accessed on 23 April 2024].
[30] Uganda Bureau of Statistics (2002) *Uganda Population and Housing Census* (administrative report) [march 2007]. Available from: https://www.ubos.org/wp-content/uploads/publications/03_20182002_CensusAdmnReport.pdf [Accessed on 23 April 2024].

1.4.1 Specific Objectives of the study

1. To analyze the international, regional and national legal and policy framework on the on the right to access health care services in Uganda.

2. To assess the financial barriers that hinder healthcare access.

3. To evaluate the infrastructure and resource gaps in healthcare facilities.

4. To identify the challenges in the implementation of constitutional provisions on the right to access health care services in Uganda.

1.5 Research question

1. What are the barriers that prevent individuals from accessing healthcare services?

2. How do we evaluate the infrastructure and resource gaps in healthcare facilities?

3. What is the international, regional and national law on the right to health in Uganda?

4. What is the role of government in constitutional implementation towards curbing the barriers to access healthcare and achieving the highest level of the right to health in Uganda?

5. What are the challenges in implementation of constitutional provisions on the right to access health care services?

1.6 Justification of the study

The justification for studying and addressing the barriers to healthcare access in Uganda is rooted in the fundamental principle of ensuring equitable and quality healthcare for all individuals and by understanding and addressing these barriers, we can work towards achieving health goals like;

Health equity is whereby access to healthcare is a basic human right and it is essential to ensure that everyone, regardless of their geographical location, socioeconomic status, or cultural background, has equal opportunities to access healthcare services. By identifying and addressing the barriers, we can strive towards achieving health equity in Uganda[31].

Also economic development; access to healthcare is crucial for socio-economic development. When individuals have good health, they can actively participate in the workforce, contribute to the economy, and break the cycle of poverty. By improving healthcare access, we can promote economic growth and development in Uganda. And many more others that we shall be looking at like sustainable development goals, social justice and improved health outcomes[32].

These justifications highlight the importance of studying and addressing the barriers to healthcare access in Uganda. By doing so, we can strive towards achieving health

[31] '*Access to and Utilization of Health Services for the Poor in Uganda*: A Systematic Review of Available Evidence.https://www.researchgate.net/publication/5290177_Access_to_and_Utilisation_of_Health_Services_for_the_Poor_in_Uganda_A_Systematic_Review_of_Available_Evidence [Accessed on 23 April 2024]

[32] RAJESH, P. (April 2020). *Health Care and Economic Development*. Available from: https://www.researchgate.net/publication/340997887_Health_Care_and_Economic_Development [accessed on 23 April 2024].

outcomes, health equity, promoting economic development and fostering social justice.

1.7 Significance of the study

The links between the barriers affecting health care access and the rate at which people access the services are established by this study. The results are anticipated to offer direction for bettering health service delivery to all the people of Uganda. In particular, the hospital's administration may use the results to inform the development of strategies aimed at enhancing patient satisfaction. The results may also prove beneficial to other public sector entities (such as other government ministries, departments, and agencies) engaged in health sector planning.

On the other hand, patients who anticipate better service delivery as a result of well-thought-out service improvement methods guided by this study may end up being the ultimate beneficiaries[33]. The study might potentially provide more research questions and information to other scholars.

1.8 LITERATUTE REVIEW

1.8.1 Introduction

Many theories have been proposed or explored to explain the existing literature on the barriers to health care access in Uganda. It further reveals what has been known in respect to cultural and societal factors that may influence healthcare-seeking.

[33] Supra note 29

Although the literature represents these theories contexts, this paper will primarily focus on the barriers to health care access in Uganda.

1.8.2 Body

The World Health Organization (WHO, 2010) lists the following qualities of good service delivery: comprehensiveness, which refers to offering a variety of health services appropriate to the target population's needs; accessibility, which means that services should be available without obstacles due to cost, language, culture, or geography; coverage and continuity; and quality, which refers to the services being safe, efficient, and patient-centered. In comparison to when they are not seen, there is a higher likelihood of utilization when the features are noted for each given service center[34].

But however much the world health Organization provides for these qualities, we still see that they are hindered by these obstacle like costs where people cannot afford the money to cover the hospital bills and many others hence the government can come up with goals like setting up fund groups in villages where people will save money which at the end will cover the hospital bills in case one is in need.

The government of Uganda has achieved significant strides in meeting several of the health-related objectives outlined in the Millennium Development Goals and their successor, the Sustainable Development Goals (SDGs), throughout the last ten years. According to Uganda Bureau of Statistics (2013) and 2020, for instance, maternal

[34] World health organization 1946 available from: https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf [Accessed on 22 April 2024]

mortality decreased by one-third between 2002/2003 and 2019/2020, from 505 deaths to 336 deaths per 100,000 live births; infant mortality decreased by half, from 87 to 43 deaths per 1,000 live births; and under-5 mortality decreased by more than half, from 156 to 64 deaths per 1,000 live births[35]. But given the fact that maternal mortality rate decreased in those years, we still have death rates going high of pregnant mothers and in order to cub that the government can ensure to employ well qualified medics to work on the patients because with such issue it comes along with unqualified persons working on the patient.

"Despite these gains, Uganda's health system continues to face a number of obstacles. The health sector remains underfunded, falling far short of the 15% budget allocation recommended by the Abuja Declaration, to which Uganda is a signatory (Initiative for Social and Economic Rights, 2018). Between 2010 and 2016, the health-sector budget averaged 7.8% of the national budget[36] (Lukwago, 2016); in 2020/2021, it accounted for 5.1% of the national budget, down from 7.9% in the previous financial year (Ministry of Finance, Planning and Economic Development, 2020)"[37].

Uganda's health system is still struggling to provide access to basic health care services especially in rural areas[38] just like in most health centers in the district and many others across the country; A report for one of the districts that is; Paminya

[35] Makanga R, Katumba. [22 July 2021]. *Priority or not? Ugandans continue to cite health as their most important problem, say access is difficult*. Available from: https://www.afrobarometer.org/wp-content/uploads/2022/02/ad465-ugandans_see_health_as_countrys_most_important_problem-afrobarometer_dispatch-21july21.pdf [Accessed on 24 April 2024].
[36] Lukwago, D. (2016). Health spending in Uganda: *Implications on the national minimum health care Package*. Advocates Coalition for Development and Environment (ACODE) Policy Briefing Paper No. 32.
[37] Ibid note 33
[38] Dr.Barry, F. [2014]. *Addressing healthcare challenges in Uganda*. Available from: https://thinkmd.org/project/addressing-healthcare-challenges-in-uganda/ [Accessed on 24 April 2024]

provides minimal care for her patients of which a physical inspection of the health clinic exposes complete hopelessness for anyone seeking medical attention. The site features run-down buildings with filthy flooring that are home to bats and some that have leaky roofs (Daniel, 2010)[39]. I further assert that when you visit most of the rural health centers in some districts in some parts of Uganda, all we can find is a healthy center standing in a tall bush, looking abandoned and in a very poor state. Hence the government of Uganda before approving some of these health centers must make sure that they are up to standard.

we see the Ugandan government implementing several initiatives to address these challenges one of them being the Uganda National Health Policy which aims to promote health, prevent illness and improve healthcare services in the country[40] I further assert that most rural health centers face the problem of being overwhelmed by the number of people that storm the health centers even when the medical personals are not enough in that area which we are still facing up to date and how is that supposed to prevent illness when there are a lot of people that be squeezing themselves in one room.

It has instead led to the spread of communicable diseases and communicable diseases or infectious diseases are caused by microorganisms such as bacteria, viruses, parasites and fungi that can be spread, directly or indirectly, from one person to another. Some are transmitted through bites from insects while others are caused by

[39] Daniel, L. [2010]. *The tragedy of Uganda's health care system. Available from*: https://www.acode-u.org/uploadedFiles/infosheet9.pdf < DOI 10. 1186/ s12889-024-17830-5>[accessed 24 April 2024]
[40] Supra note 35

ingesting contaminated food or water[41]. In short the government of Uganda can set up more health centers to avoid over crowdness.

Economic barriers. Respondents reported that poverty or lack of money, expensive transportation cost, and lack of food to eat, lack of facemasks to protect COVID-19 as the main barriers of health and nutrition service access. A 40 years old female subject explained the effect of lack of money and food on service access as follows: "there is no money to pay for transportation and food to eat. Sometimes, when you are hungry and your body is weak to walk to health facility, stay sick at home is better"[42]. I therefore assert that those challenges are still affecting people up to now where food is scarce and they end up getting malnourished hence dying. Hence the government of Uganda could make it appoint to encourage people to carry out farming in order to sustain themselves.

Another respondent also said, "Due to the drought, our cattle has died, there-fore no money to buy drugs and food, even some drugs require food to swallow (A 30 years old, male subject)[43]. I therefore assert that those problems still exist due to the high levels of poverty where by people cannot access some medicines for example some government hospitals still lack enough medicines for patients hence they end up prescribing for them the medicines they require to go and buy them somewhere else

[41] World Health Organization 1946. Available from: https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf [accessed 23 April 2024]
[42] Ibid note 36
[43] Njuguna et al. BMC public Health (2024*). Perceived Barriers of Access to Health and Nutrition Services under Drought and Food insecurity Emergency in North-East Uganda-a qualitative study*. Available from: https://www.researchgate.net/publication/378009272_Perceived_barriers_of_access_to_health_and_nutrition_services_under_drought_and_food_insecurity_emergency_in_north-east_Uganda_a_qualitative_study [accessed 24 April 2024]

well knowing that that person has no money to buy those medicine and it is expensive. Hence the government can ensure that enough medicines are supplied in these hospitals.

The stories of the health workers and patients alike reveal the tragedy of our national healthcare system in spite of a national budget that has been increasing over the years. There are major challenges that have to be addressed if Ugandans who depend on our public healthcare system are to benefit from the investments our government makes in the health sector. These include: underfunding, understaffing, lack of accommodation, inconsistent drug distribution.

The Government of Uganda under the Ministry of Health has increased the number of health facilities throughout the country in recent years. However, there are still disparities between urban and rural areas, as well as by geographic location therefore certain communities have more access to health services than others[44].

The lack of public facilities in some communities, which are predominantly used by the poor, is likely to affect the health seeking practices of the population. This problem of inequity in health facility distribution affects the health seeking practices of several communities hence hindering health services utilization (David Musoke et al)[45]. I therefore concur with the writer that some areas be having better facilities compared to others taking an example of areas in town can be having enough

[44] Ibid note 40

[45] David musoke, et al (2014) African health sci. *Health Seeking Behavior and Challenges in Utilizing Health Facilities in Wakiso District, Uganda*. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4370086/#ref-list-a.m.dtitle: [accessed 24 April , 2024]

facilities compared to those in rural areas. Hence I encourage the government to practice equality because health care services are needed by everyone irrespective of their position or gender.

Infrastructural related barriers are one of the categories that emerged under the environmental related theme. The majority of the participants reported that bad roads, hard-to-reach areas, poor communication network, and long distance to health facility were the main barriers that hinder the patients from accessing health and nutrition services[46].

One subject interviewed described as below: "In the event of an emergency, the poor road net-work complicates the use of ambulance for referral service. Poor roads and long distances make harder to reach to the facility (A 25years old male subject)." Another subject interviewed said, "Distance to health facility is the main challenge to get to health facility to access service. As Boda Boda (motor bicycle) is a common transportation means in our area, it is not suitable for the subject especially on bad road. Poor network connectivity is also the main challenge to get help from health facility[47].

The road is not good to go to bigger hospital, and there is no ambulance during bad condition (A 25years old male subject)." And I strongly argue that we still experience a problem of poor roads where some mothers have experienced cases of travelling long distances from their home area to where the main hospital is which is a very long

[46] supra note 37
[47] Ibid note 44

distance and travelling on poor roads where some of them end up not making it and either give birth on the road or end up kicking the bucket.

Health facility related barrier was one of the two categories that emerged under health system related barriers theme. Study participants mentioned that waiting time, early closure of the health facility, frequent drug stock-outs, lack of health workers, lack of in-patient services, lack of nutritional services, lack of privacy, poor sanitation in health facility, and poor quality of service were the barriers of access to health and nutrition services[48].

A subject explained as, "How I go to health facility because very few health workers present in the health facility to deliver service on some days which leads to very long waiting hours, and many subjects to wait for the service (A 21years old female subject)."Another subject was also explained "there is no medicines in the health center, few services and health professionals are present in the health center (A 31years old female subject[49]. It is mostly common in government hospitals where workers go on strike like the whole day living patients in hospitals to suffer yet they need immediate care and attention they do that due to the low salaries given to them. Hence the government should increase the wages of these health workers in order for them to enjoy what they are doing.

[48] Supra note 42
[49] Ibid note 46

According to an abstract[50], it was reported that few health units had running water, electricity or a functional operation theater in a survey covering 54 districts and 553 health facilities. It was also assessed that the availability of midwives had the highest productive effect on maternal deaths reducing the case fatality rate by 80%,97.2% health facilities expected to offer basic Care were not doing so . Which is the likely explanation for the high health facility based maternal death rate of 67/100000 live births in Uganda. And of which these maternal deaths are still occurring due to the same problems. I agree with the writer because in most private health centers, those services are paid by the directors of those hospitals where sometimes it is overwhelming for them and end up not paying and in that process patients are left in the dark and with no water. Hence the government of Uganda should give those private facilities free services like water, electricity and others.

Good quality maternal health services are those that, among other things, are easily accessible; safe, effective, acceptable to potential users, and staffed by technically competent people; they also provide timely comprehensive care or links to other reproductive health services; they provide a continuity of care, and the staff is helpful, respectful, and nonjudgmental, according to D. Kaye, a lecturer at Makerere University[51].

[50] Declining maternal mortality ration in Uganda; https//do.og/10.1016/j.igo.2007.05.019 9 [accessed 25 April , 2024]

[51] Kaye, D. (2000). *Quality of Midwifery Care in Soroti District*: Uganda. East African Medical Journal, 77,558-561.

According to Thomas J. Papadimos, access to healthcare is supported by western philosophy as a "right" rather than a "privilege." States are able to partially evade their commitments due to the loophole created by the progressive realization obligation. In fact, some regimes have claimed that economic, social, and cultural rights are merely aspirational aims and cannot be justified due to progressive realization. Progressive realization, however, must be interpreted as a duty on the part of states parties to precede as quickly and effectively as feasible towards the complete realization of the relevant right, as noted in General Comment 3 of the CESCR.[52]

Judith Asher aims to remove obstacles that have prevented the quick adoption of human rights in the medical industry. She goes on to discuss the duties imposed by the right to health. She specifically discusses the state's responsibility to uphold, defend, and fulfill the right to obtain health care, but delightfully, she also includes a section on the responsibilities of non-state actors and foreign partners. Asher provides more information on how to apply rights to advocacy and oversight work[53].

Michael L. Perlin illuminates how persons with health disabilities are still being neglected, which is a violation of human rights law. In spite of a unique international legal framework, the human rights climate for people with mental disabilities is among the worst in the world. Perlin contends that social negligence, a lack of

[52] Committee on Economic, Social and Cultural Rights, General Comment 3, the nature of states parties obligations.
[53] Tino, M. (2013*). The right to health in the legal framework of Uganda*- the missing linking chapter 1. Available from: https://www.researchgate.net/publication/236009553_THE_RIGHT_TO_HEALTH_IN_THE_LEGAL_FRAMEWORK_OF_UGANDA-_THE_MISSING_LINK_CHAPTER_1 [accessed 22 may 2024]

adequate or nonexistent legal protection against violations of the right to health, and prevailing sanism and pretextual attitudes are the root causes of these inhumane conditions[54] .

In 2000, the ICESCR committee adopted General Comment No. 14, which outlined a four-step criterion (AAAQ criteria) that should be applied when evaluating the right to health. Among them were;

Availability: this calls for initiatives and high-quality services that must be easily accessible and offered in enough numbers.

Accessibility: This implies that, among other things, discrimination should not be practiced based on a person's ethnicity, sex, religion, or nationality. The services should be reasonably priced, physically accessible, and provide access to health information and any recent advancement.

Acceptability: According to this criterion, gender sensitivity should be considered when providing health services, and facilities, goods, and services should be acceptable to the target group and culturally relevant.

Quality: This means, among other things, that the healthcare facilities should be of high quality, the products and services should be of high quality and not have expired

[54]Ibid note 51

in the case of pharmaceuticals, the health personnel should be trained to provide high-quality services, and so on[55].

1.8.3 CONCLUSION

After conducting an in depth review of the existing literature, this research proposal aimed at filling in the gaps identified which contribute to the existing research on barriers to health care access. Where the review highlights the steps the government can take in addressing these barriers through community outreach, improved infrastructure and many others and by understanding and addressing these barriers, we can work towards achieving equitable access to health care for all individuals.

1.9 METHODOLOGY

1.9.1 Introduction

This chapter describes the different methods the researcher used to carry out the study. The various methods included data collection, selection, research designs, sample size, area and population study, data processing, presentation and analysis, ethical issues thus, this section dealt with the research instruments used in investigating the problem. It involved the ways in which the respondent was selected; it also contained the methods and procedures used to analyze data. Here the researcher used the qualitative research methodology together with its designs, techniques and methods.

[55] World Health Organization (2023) available from: https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health [Accessed 28th April 2024]

1.9.2 Research design

The researcher collected data using the desktop research review method. The study, which combines desktop research with qualitative data collection, is entirely doctrinal in character. The main components of the research were content analysis of previously published publications and the text of law.

The study included a desk review of the theories on barriers to access health care, the effective laws and policies governing access to health care in Uganda as well as the level of awareness among the citizens of Uganda.

1.9.3 Secondary data: Can be gathered without visiting the field; in this case, the researcher employed statistical tools and produced reports

The research included online surveys in Uganda and already existing samples of barriers hindering access to healthcare belonging to different parts of the country. The researcher also collected data from specialized and general libraries.

The ideal way to conduct this study is to employ the desktop technique, which saves money on budgeting and requires less time because it doesn't require moving to gather information—all information is done on a desktop using previously published materials. Finally, the researcher selected the desktop review research method in order to obtain information from persons who the researcher is unable to meet.

1.9.4 Data collection instruments

The researcher used desktop and qualitative methods as the data collection method. The desktop review method of research focused on data pertaining the effective laws and policies on the barriers to access health care services in Uganda. The researcher reviewed various reports, articles, laws, books, case law which establish the topic or study to establish whether they have been respected and upheld.

1.9.5 Conclusion

In the collection of the data, the researcher therefore explored both quantitative and desktop review research approaches which involved review of doctrinal literature. The research findings from scholarly materials, laws and journal provided the clear understanding of the analysis on the barriers to health care access in Uganda.

1.10 LIMITATIONS OF THE STUDY

The major constraint/limitation of this research is that there is limited literature in regards to the topic of study thus a difficulty in carrying out this research.

Also the time for carrying out this research is very limited thus some methods of data collection like interview won't be done due to the limited time.

1.11 CHAPTER SYNOPSIS

This proposal is divided into three chapters.

The first chapter assesses the background of the problem for instance what healthcare is all about, the extent of the problem, assesses the statement of the problem that is the reality, ideal situation and the consequences. This chapter also stipulates the objectives, justification and significance of the study.

Chapter one also examines the literature review of the study and the methodology that will be used while conducting the research.

Chapter 2 will discuss the non-legal aspects regarding the effectiveness of laws and policies against barriers to health care access in Uganda.

Chapter 3 will discuss the legal regime/aspects governing the topic of study.

Chapter 4 shall be a summary of findings, conclusions and recommendations on the effectiveness of laws and policies on the barriers to health care access.

In a nut shell, generally this chapter (chapter one) provides for or entails the general background or aspects of the study in entirely. As indicated above in the synopsis, the chapters following shall entail deeper discussions in regards to the study and further recommendations.

CHAPTER TWO

THE NON LEGAL ASPECTS OF THE BARRIERS TO HEALTH CARE ACCESS IN UGANDA

2.1 INTRODUCTION

This chapter provides an overview of the non-legal components of healthcare barriers and will discuss the reasons behind them in Uganda. It offers insight into the idea of health care, the necessity of removing obstacles to healthcare, the elements that make up quality healthcare, and the important points will always be emphasized.

Health is a state of physical, mental and social well-being in which disease and infirmity are absent.[56] It was however satisfactorily defined as a state of complete physical, mental, and social wellbeing, and not merely the absence of disease[57]

2.2 Components of health care

2.2.2 Health promotion

By integrating a variety of techniques, health promotion aims to increase both individual and group participation in health-related initiatives and to fortify existing

[56] Callahan, D. (1973). The WHO Definition of "Health." The Hastings Center Studies, 1(3), 77–87. https://doi.org/10.2307/3527467. Available at: https://www.jstor.org/stable/3527467.[Accessed on 17th May 2024]

[57] Gro, H. (2000). The World health organization, report. Health system: *Improving performance*. Available at: https://books.google.co.ug/books?hl=en&lr=&id=luqgKK2euxoC&oi=fnd&pg=PR7&dq=World+health+organization,+report.(1990)&ots=sOi979CY9&sig=s0otH7HJ8eS5gM5mPuKDDxP1yt8&redir_esc=y#v=onepage&q=World%20health%20organization%2C%20report.(1990)&f=false . [Accessed on 17th May 2024].

programs.[58] These techniques are integrated through all-encompassing strategies that guarantee activity at all societal levels, improving the influence on health[59].

Although the concept of health promotion has been around for a while, the phrase remained limited to one particular field until the 1980s.[60] The development of health promotion was greatly influenced by the evolution of other broad approaches to human development such as, the growing recognition of poverty as a major underlying cause of illness, the growing calls for social justice and the rights of women, children, and minorities, the health-for-all concept, and movements to protect and improve the physical environment[61].

"The global quest for efficient ways to prevent illness and enhance the quality of life in general has led to the development of health promotion.[62] In order to enhance health, there has been a growing understanding of the necessity of addressing behavioral, lifestyle (including detrimental cultural practices), and other underlying socioeconomic, physical, and biological factors—collectively referred to as the broad determinants of health"[63].

[58] Egger, G. et al. (1990). *Health promotion strategies and methods*. Mc. Gram-Hill Book company, Sydney, p.5. Available at: https://www.afro.who.int/sites/default/files/2017-06/hpr%20-%20strategy%20for%20african%20region.pdf. [Accessed 27th April 2024].
[59] Egger, G. et al. (1990). *Health promotion strategies and methods*. Mc. Gram-Hill Book Company, Sydney, p.5. Accessed from: https://www.afro.who.int/sites/default/files/2017-06/hpr%20-%20strategy%20for%20african%20region.pdf [Accessed on 27th April 2024]
[60] Ibid note 4
[61] Ibid note 48
[62] Supra note 3
[63] Ibid note 49

2.2.4 Curative care (diagnosis and treating acute illness and injury)

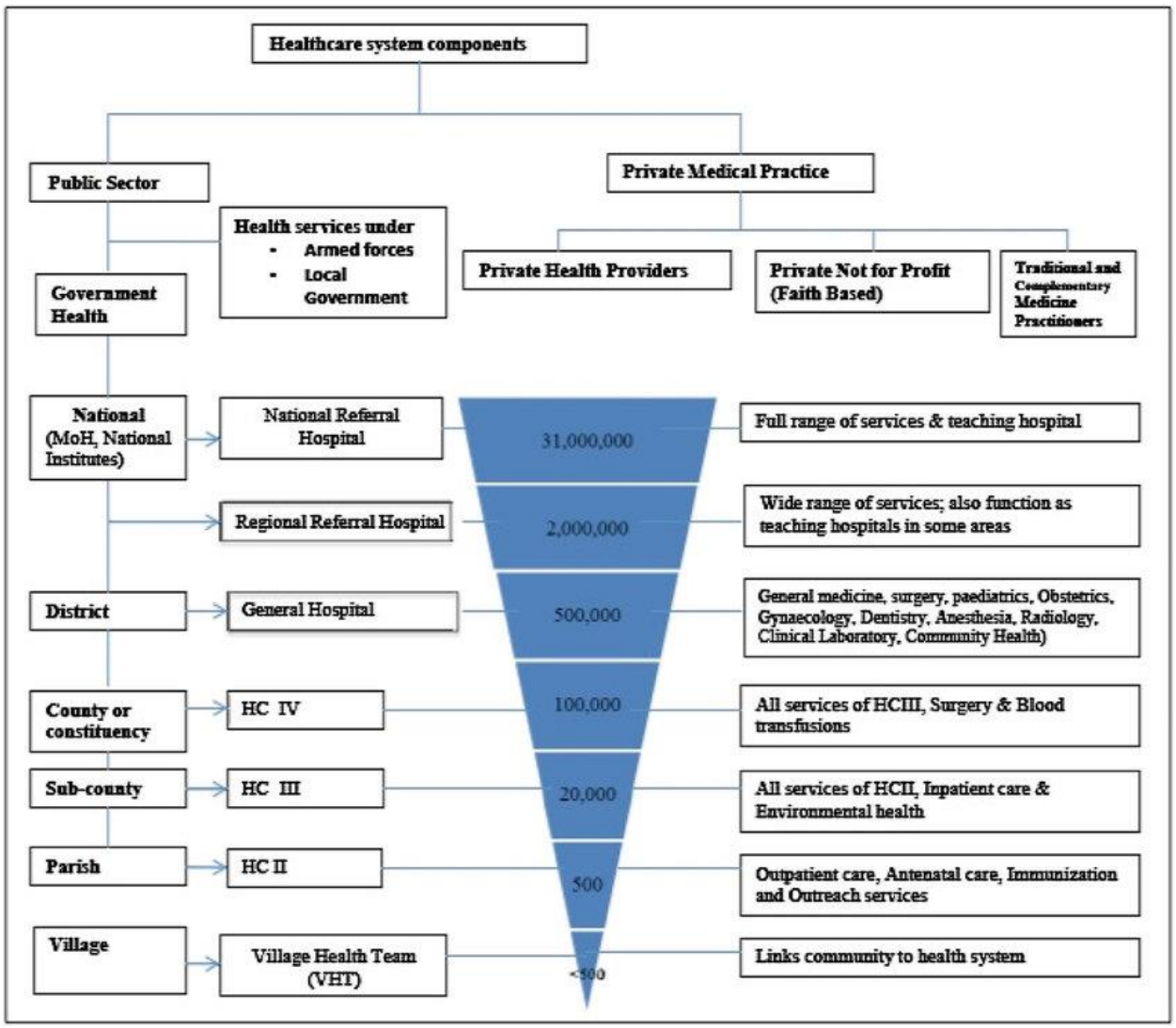
A major cause of the unfavorable patient outcomes in these environments is the general shortage and unequal distribution of healthcare professionals[64]. Physicians are noticeably scarce especially in rural locations where child death rates are highest[65] because they are not qualified to identify emergencies and act quickly, non-physician clinicians handle patients with acute illnesses and injuries, particularly in remote places.[66]

2.2.5 Rehabilitative care (monitoring and treatment of chronic illness and disability)

To enable persons with physical disabilities live more independently and with more function, Kawempe division offers free and subsidized rehabilitation treatments at Katalemwa Rehabilitation Center and Mulago Hospital Physiotherapy Department. The reasons behind the high number of physically disabled individuals who do not use the services are unknown. Furthermore, nothing is known regarding the frequency with which individuals with physical disabilities use rehabilitation services. Records from the Katalemwa Rehabilitation Center and Mulago Physiotherapy Department indicate that just 15.2% (3000 out of 19,776) of the PWDs in the division have made use of the services[67]

[64] World Health Organization. The world health report (2006). *Working together for health*. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4388510/#pone.0122559.ref002 [Accessed on 28 April 2024]
[65] Uganda demographic and health survey.*(2011). Uganda Beaurea of statistics,* Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4388510/#pone.0122559.ref003 [accessed 28 April 2024]
[66] Ibid note 11
[67] Swaibu, Z, et al. (2019). *Prevalence and factors associated with utilization of rehabilitation services among people with physical disabilities in Kampala*. Available from: https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-019-8076-3 [Accessed 28 April 2024].

2.3 Structure of the health system in Uganda[68]



2.4 The health care system in Uganda and their roles

i) National level institutions and ministry of health headquarters

Roles of the national level institutions and ministry of health headquarters.

Resource mobilization and budgeting

[68] Susan, C.W. (2016). *Structure of the health system in Uganda*. Available from: https://www.researchgate.net/figure/Structure-of-the-health-system-in-Uganda_fig1_303423939 [accessed 28 April 2024]

Policy formulation and dialogue with heads of departments

Set standards and quality assurance

Advise other ministries, departments and agencies on health related matters

Coordinate health research

ii) Regional referral hospital

Roles of regional referral hospitals

Supervise and support health system at the regional level

iii) District/local government

Roles of the district or the local government.

Supervise and monitor all health services at district level both public and private

Foster community development in the planning management and delivery of health care

Develop and pass health related by-laws

Recruit, deploy and manage district health staff

2.5 Characteristics of a good health care system in Uganda.[69]

2.5.1 Patient centered

A good health care system should be in position to understand the needs of the stakeholders, pay attention to their priorities and give them the requisite accountability. Furthermore, it should foster rights based approach, social justice and equity[70].

2.5.2 Service oriented

A good health system should focus on rendering the best service to its patients[71].

2.5.3 Efficiency and effectiveness

A well-functioning health system ought to accomplish its stated aims and objectives. Positive health-promoting behaviors like spacing out children and the patient's gratitude for the services received are examples of potential indicators that can be used to gauge efficacy and efficiency[72]

2.5.4 Accessible

This largely depends on the health facility's scope and capacity to reach out to many patients. Accessibility can also be looked at through the lenses of the distance one has to move to get the service.

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[69] Rockville, MD. (2015). Agency for health care research and quality. *Six domains of healthcare quality*. Available from:https://www.ahrq.gov/talkingquality/measures/six-domains.html [accessed 3 may 2024]
[70] Ibid note 15
[71] Ibid note 16
[72] Supra note 15

2.5.5 Affordable

A good health system should offer affordable services to its patients[73].

2.5.6 Responsive.

This has to do with moral concerns like secrecy, autonomy, and respect. This also includes aspects of customer care including the time spent with patients and the caliber of services provided[74].

2.6 BARRIERS THAT HINDER THE HEATH CARE ACCESS IN UGANDA

2.6.1 Limited infrastructure

The barriers that hinder the health care access in Uganda are quite very many but I am going to discuss the major ones below.

One of the major challenges is limited infrastructure. In many parts of Uganda, especially rural areas, there is lack of well-equipped health care facilities. This scarcity makes it difficult for individuals to receive timely and quality health care services. People may have to travel vast distances to obtain medical care due to inadequate infrastructure, which can be difficult for individuals with restricted mobility or financial resources. Additionally, the shortage of healthcare facilities can result in overcrowding and longer waiting times, further hindering access to health care[75].

[73] Supra note 15
[74] Supra note 15
[75] Limi, A. (2021). *Estimating the impact of improved Roads on Access to health care*: Evidence from Uganda Available from: https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-024-17830-5#ref-CR37 [accessed 26 April 2024]

Flooding and a lack of roads during the rainy season were also cited as seasonal obstacles to accessing nutrition and health services. The previous study found that transportation accessibility to health facilities is a significant driver of access to healthcare, which is similar to the findings of this study, which highlighted poor road conditions as a barrier to obtaining nutrition and health services[76].

The subjects of the current study noted that obstacles to accessing health and nutrition services included things like bad roads, a long commute to a healthcare center, residing in remote places, and a weak communication network. The findings of the current study, which found that a poor road was the obstacle to accessing nutrition and health services, are consistent with the findings of earlier studies[77].

Furthermore, a study indicated that traveling a long distance to a medical facility seemed to be a barrier to receiving healthcare services, which was in line with the findings of the present investigation that showed that getting nourishment and health services was hampered by having to travel a considerable distance to a medical facility. The majority of people living in the research area are pastoralists, and their remote living has been identified as a barrier to receiving nutrition and health assistance[78].

[76] Ibid note 21
[77] Ibid note 48
[78] Musoke, DB. et al. (no date). *Health seeking behavior and challenges in utilizing health facilities in Wakiso District, Uganda.* Afr Heal sci. 2014: 14(4): 1046-55. https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-024-17830-5#ref-CR39 [accessed 26 April 2024]

2.6.2 Transportation

Transportation is another crucial aspect that affects healthcare access. In Uganda, inadequate transportation infrastructure, especially in rural areas, can make it challenging for individuals to reach health care facilities. Lack of proper roads, public transportation, or affordable private transportation options can pose significant barriers. This issue is especially pronounced during emergencies when quick access to medical care is crucial. The absence of reliable transportation can delay or even prevent individuals from receiving timely medical attention, exacerbating their health conditions.

Uganda's health services have been known for being unfair or inequitable[79], with the wealthy receiving more services than necessary while the impoverished receive fewer services than necessary[80] Distance to government health facilities is a barrier, according to qualitative research, because of the costs of missed opportunities incurred by traveling to the facility and because it is too far away[81]. Similar to this, poorer Ugandans are influenced by limited geographic access to healthcare facilities

[79] Zikusooka C, et al. *Is health care financing in Uganda* equitable? Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7814723/#CR13 [26 April 2024]
[80] Kwesiga B, et al. (2015). *Who pays for and who benefits from health care services in Uganda?* BMC Health Serv <Res.2015: 15(1):44. Doi: 10. 1186/S12913 -015-0683-9> Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7814723/#CR14 [Accessed 26 Aril, 2024]
[81] Hoof A, Nabukalu D, et al. (2020). *Factors Motivating Traditional Healer versus Biomedical Facility use for Treatment of Pediatric febrile illness*: Results from a qualitative study in southwestern Uganda. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7814723/#CR15 [accessed 26 April 2024]

to seek care from the closest facility or provider, even if the quality of care is inferior.[82]

Several researches on the utilization of health care among Ugandans have referenced the relationship between poverty and access to healthcare[83]. Resulting in a greater dependence on family, community, and conventional health care sources rather than seeking medical attention from a professional[84] on a nationwide scale, however, the connection between health care access and poverty has not been quantitatively modeled.

Significant obstacles relating to transportation make health care for Uganda's impoverished population extremely difficult[85]. Non-Governmental Organizations (NGOs) and Social Enterprises have suggested and encouraged the ownership of bicycles as a means of lowering travel-related obstacles to health care (including market access) by providing affordable, sturdy bicycles and bicycle ambulances. Although owning a bicycle has been linked to greater use of maternal health services[86] to the best of the author's knowledge, no studies have been done to measure and

[82] Kiguli J, Okui O, et al. Increasing access to quality healthcare for the poor: *community perceptions on quality care in Uganda*. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7814723/#CR15 [accessed 26 April 2024]

[83] Musinguzi LK, et al. (2017). *Linking communities to formal health care providers through village health teams in rural Uganda*: lessons from linking social capital). Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7814723/#CR17 [accessed 26 April 2024]

[84] Allen EP, et al. (2017). Health Facility Management and Access: *A qualitative analysis of challenges to seeking health care for children under five in Uganda*. <Doi: 10.1093/heapol/Czw180>. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7814723/#CR19 [accessed 26 April 2024]

[85] Wandera SO, et al. (2015). Determinants of access to health care by older persons in Uganda: across-sectional study. < Doi: 10.1186/S12939-015-0157-z>. available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7814723/#CR20 [accessed 26 April 2024]

[86] Tanou M, Kamiya Y. (2019). *Assessing the impact of geographical access to health facilities on material healthcare utilization*: evidence from the Uganda demographic and health survey 2010. <Doi 10.1186/S 12889-019-7150-1> available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7814723/#CR21 [accessed 26 April 2024].

investigate the connection between poverty and the potential time savings that bicycles provide when compared to walking scenarios when accessing health care services across the nation[87].

2.6.3 Cultural beliefs

Cultural beliefs and stigmas also play a role in healthcare access. In some communities, cultural norms and practices may discourage individuals from seeking medical help or accessing certain healthcare services. For example, there may be stigmas surrounding mental health issues, reproductive health, or certain diseases. These stigmas can prevent individuals from seeking appropriate care, leading to delayed diagnosis and treatment. Addressing cultural beliefs and stigmas through education and community engagement is vital to improving healthcare access for all.

While cultural beliefs can be a source of resilience and strength, there are also factors that may unintentionally have a detrimental effect on mental health. Among the negative outcomes include stigmatization, discrimination, and the suppression of conversations about mental health[88]. People may find it difficult to seek professional assistance or to express their emotions in public due to societal standards that prevent doing so.

2.6.4 Cultural Myths around Mental Health:

[87] Ibid note 32

[88] Nile post. (17th November 2023). Cultural perspectives and mental health in Uganda. Available from: https://nilepost.co.ug/health/178931/cultural-perspectives-and-mental-health-in-uganda#:~:text=Cultural%20myths%20surrounding%20mental%20health,evil%20spirits%2C%20or%20moral%20failings. [Accessed 26 April 2024]

Deeply ingrained cultural stereotypes about mental health in Uganda add to the stigma that permeates the community. Typical misconceptions include attributing mental health issues to moral shortcomings, demonic possession, or curses. These false beliefs frequently lead to the exclusion of people dealing with mental health concerns from their communities, which exacerbates their difficulties[89].

Impact on Recognition, Identification, and Management:

The cultural environment has a big impact on mental health awareness, diagnosis, and care. Inadequate knowledge could lead to postponed action, and the stigma around mental health problems can prevent candid conversations. Cultural prejudices can make diagnosis difficult, and evidence-based treatments may not always take precedence over traditional healing methods[90].

2.6.5 Health professional shortage

This is crucial to know since, in Uganda, where there is roughly one doctor and one nurse for every 24,725 and 18,000 people, respectively, staffing shortages continue to be a major problem[91]. Respectively the majority of those who are concentrated in cities[92]

[89] Ibid note 59
[90] Ibid note 61
[91] MOHU. *Annual health sector performance report: financial year 2019/20. Kampala*: ministry of health Uganda; 2020. Available from: https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-020-01371-5#ref-CR68 [accessed 26th April 2024]
[92] MOHU. *Human resources for health bi-annual report*: improving HRH Evidence for decision making October 2014/march 2015. Kampala: ministry of health of health Uganda; 2015 available from: https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-020-01371-5#ref-CR69 [accessed 26th April 2024]

In Uganda, there is a shortage of health professionals, including doctors, nurses, and other healthcare providers[93]. This shortage is due to various factors such as limited training opportunities, brain drain (where skilled professionals leave the country for better opportunities), and inadequate funding for healthcare education and infrastructure. As a result, there aren't enough healthcare providers to meet the healthcare needs of the population. This shortage leads to longer wait times, limited access to specialized care, and lower quality of healthcare services. It's a complex issue that requires attention and investment in healthcare education and recruitment[94].

Conclusion

In conclusion, when it comes to the non-legal aspects of barriers to health care access in Uganda, there are a few things to consider. Health promotion and disease prevention play a crucial role in improving access to healthcare. Additionally, rehabilitative care is important for those who need ongoing treatment. A good healthcare system should have characteristics like affordability, availability, and quality services. However, there are barriers in Uganda that hinder healthcare access, such as limited resources, inadequate infrastructure, and geographical challenges. These barriers make it harder for people to receive the care they need.

[93] Ibid note 38
[94] Supra note 38

3.0 CHAPTER THREE: LEGAL FRAMEWORK ON THE BARRIERS THAT HINDER THE HEALTH CARE ACCESS IN UGANDA.

3.1 INTRODUCTION

The Universal Declaration of Human Rights (UDHR),[95] the Convention on the Rights of the Child (CRC)[96], the ICESCR,[97] CEDAW[98], the CRPD, and many other international instruments that uphold the right to health have all been approved by the Ugandan government. Uganda is a member of the World Health Organization (WHO), which defines health as a state of whole bodily and mental well-being as opposed to just the absence of illness or disability[99] prior to 2015, lowering maternal mortality was the goal of Millennium Development Goal (MDG) 5 in the international policy framework. SDG 3 addresses improving health and well-being as well as eradicating inequities within and between countries. The Sustainable Development Goals (SDGs) now provide a policy framework aimed at altering the globe for sustainable development by 2030[100].

[95] United Nations (UN) (1948) Universal Declaration of Human Rights. Accessed from: https://www.un.org/en/udhrbook/pdf/udhr_booklet_en_web.pdf [Accessed 3 may 2024]
[96] Convention on the Right of the Child (1990). Available from: https://www.ohchr.org/sites/default/files/Documents/ProfessionalInterest/crc.pdf [Accessed 3 may 2024]
[97] United Nations (UN) (1967) International Covenant on Economic, Social and cultural Rights. Available from: https://treaties.un.org/doc/treaties/1976/01/19760103%2009-57%20pm/ch_iv_03.pdf [accessed 3 may 2024]
[98] Convention on the Elimination of all forms of Discrimination against Women (1981). Available from: https://www.ohchr.org/sites/default/files/Documents/ProfessionalInterest/cedaw.pdf [accessed 3 may 2024]
[99] Callahan, D. (1973). The WHO definition of'health'. Hastings Center Studies, 77-87.
[100] UN (2015) 'Sustainable Development Goals: 17 goals to transform our World,' UN, New York at. Available from: http://www.un.org/sustainabledevelopment/sustainable-development-goals [Accessed 3 may 2024]

Since Uganda's Constitution does not specifically address obstacles to healthcare access,[101] this chapter looks at important legal frameworks that support the right to health, with an emphasis on regional, national, and international legislation.

3.2 International Law on the right to health

The following list of international laws pertains to the right to health and the year Uganda ratified each law is indicated in brackets.

3.2.1 The Universal Declaration of Human Rights[102].

A standard of living sufficient for everyone's health and well-being, including food, clothing, housing, medical care, and security in case of illness, is guaranteed under Article 25(1) of the UDHR. The UDHR's Article 25(2) promotes maternal care by guaranteeing mothers preferential treatment and support as well as protection for all children whether they are born into or out of wedlock. Furthermore, the right to freely engage in community cultural activities and to benefit from scientific advancements is outlined in article 27(1) of the UDHR.

This encourages the use of contemporary medical services as well as conventional health care. Lastly, article 30 makes it quite plain that no state, organization, or individual may interpret the UDHR in a way that undermines any right. Therefore, the

[101] Ibid note 38
[102] United Nations (1948) Universal Declaration of Human Rights. Accessed from: https://www.un.org/en/udhrbook/pdf/udhr_booklet_en_web.pdf [Accessed 3 may 2024]

right of Ugandans to obtain healthcare services cannot be compromised by any of the UDHR provisions[103] .

3.2.2 Internal covenant on Economic, social and cultural Rights[104]

The right to the best possible bodily and mental health is recognized by the ICESCR in Article 12, which also outlines the steps the state must take to effectively implement the right. Specifics include lowering the rates of stillbirth and infant mortality, enhancing industrial hygiene and environmental conditions, preventing, treating, and controlling diseases, and guaranteeing that everyone will have access to healthcare in the event of illness. In accordance with article 2(1), the state committed to gradually achieving the full fulfillment of human rights by making the most use of all of its resources[105].

To provide its people with the best quality healthcare possible, Uganda must implement both qualitative and quantitative methods. The AAAQ framework in General Comment 12 on the right to health, which mandates that healthcare be available, accessible, and of sufficient quality, can be used to evaluate how well a state is performing.

Furthermore, safe and healthy working conditions are guaranteed under ICESCR article 7(b), and working women are entitled to paid leave, sufficient social security benefits, and special protection for a fair amount of time before to and following

[103] Assembly, U. G. (1948). Universal declaration of human rights. UN General Assembly, 302(2), 14-25.
[104] United Nations (UN) (1967). *International Covenant on Economic, Social and cultural Rights*. Available from: https://treaties.un.org/doc/treaties/1976/01/19760103%2009-57%20pm/ch_iv_03.pdf [accessed 3 may 2024]
[105] Ibid note 50

childbirth under Article 10(2)[106]. As a crucial success factor for its realization, Article 11(1) declares that everyone has the right to an adequate standard of life, which includes enough food, clothing, and housing, as well as the ability to continuously enhance these things through international collaboration based on free consent[107].

In addition to guaranteeing freedom from hunger, Article 11(2) requires states to work together both individually and globally to enhance food production, distribution, and conservation through the application of technical and scientific knowledge, the sharing of nutritional information, and agrarian reforms. Article 5(1) forbids using the ICESCR to support actions that are detrimental to any of the freedoms or rights enumerated therein. Even better, article (2) forbids the limitation or derogation of numerous rights under the guise that the ICESCR either partially or not at all recognizes them[108].

Article 16 of the ICESCR, which deals with accountability, requires the state to report to the UN Secretary-General on the steps taken to realize the right to health. According to article 17(2), the reports may highlight issues that have an impact on how well duties are fulfilled. Copies are then forwarded by the secretary general to the specialized agencies and the Economic and Social Council (ESC) for review. Additionally, under Article 19, the ESC may forward the reports to the Commission on Human Rights (CHR) for analysis, broad advice, or pertinent data[109].

[106] Supra note 50
[107] Ibid note 50
[108] Supra note 50
[109] Supra note 50

According to article 20, the state may provide ESC with feedback or citations on any report's general recommendation. Furthermore, the ESC may provide recommendations to the general assembly and other UN bodies under articles 21 and 22 that could help them decide on international actions that would be necessary for the successful progressive implementation of those measures[110].

Such international action is defined in detail in Article 23 and includes concluding conventions, adopting recommendations, providing technical support, and hosting regional consultative meetings with states that are impacted[111].

"With so many interconnected health rights in the ICESCR and so many tools and organizations accessible to evaluate its implementation, Ugandans have many opportunities to advance their right to healthcare. The right to health, for instance, is outlined in depth in the ICESCR, together with the circumstances under which it should be exercised and the elements that are necessary for its realization, particularly with regard to pregnancy. The ICESCR also gives residents and states multiple ways to implement the law, as well as tools for monitoring progress and figuring out what has to be done to rectify failures"[112].

In order to guarantee that the state is held accountable for protecting the right to health and carrying out its duties, the ICESCR, finally, establishes a varied

[110] Supra note 50
[111] Ibid note 55
[112] Hammonds, R., et al. (2019). UHC2030's contributions to global health governance that advance the right to health care: A preliminary assessment. *Health and human rights*, 21(2), 235.[Accessed on 17th may 2024]

institutional ecology. The most important query that emerges is "how much has Uganda taken advantage of these opportunities?"

3.2.3 The Convention on elimination of all forms of discrimination against women[113]

The CEDAW, Article 4(2) exempts special measures adopted to protect maternity from being discriminatory. Article 5(b) obliges the state to take all appropriate measures to ensure that family education includes a proper understanding of maternity. Article 11(1) entitles employed women to healthy and safe working conditions, protection of their reproductive function and paid maternity leave. Article 11(2) and (3) cover prevention of discrimination against women on grounds of maternity by obliging states to prohibit unfair dismissal, introduce paid maternity leave or comparable social benefits, guarantee job security and periodically review protective laws in line with scientific or technological knowledge[114].

In the case of Olga Seniv v Tamem Michael Bridal Limited[115], (DEC-EC2010-096) the plaintiff sued for discrimination when the defendant dismissed her upon return from maternity leave, and her replacement continued to carry out her former duties. The Equality Offer held that the defendant had discriminated against her on grounds of gender and ordered compensation of 20,000 euros for the effects of the discriminatory dismissal (UN, 1979).

[113] Convention on the Elimination of all forms of Discrimination Against Women (1981). Available from: https://www.ohchr.org/sites/default/files/Documents/ProfessionalInterest/cedaw.pdf [accessed 3 may 2024]
[114] Supra note 59
[115][115]Charlie, T. (2010). Woman wins maternity dispute. Available at: https://www.irishtimes.com/news/woman-wins-maternity-dispute-1.861331 [accessed May 17, 2024].

Additionally, CEDAW's Article 12 guarantees equal access to suitable health care, such as family planning, confinement, free services when required, and sufficient nutrition during pregnancy, the post-natal period, and the location of the facility. Article 14(2) requires the state to guarantee that grassroots women have access to adequate family planning, health care, information, and counseling, as well as adequate housing, sanitization, electricity, water transportation, and communication. They also have to be included in the development, implementation, and benefits of rural planning and development[116].

Article 17(1) of the CEDAW created a Committee on the Elimination of Discrimination against Women to review the implementation progress in order to ensure enforcement and accountability. Elected by their respective states, it is composed of eighteen to twenty-three morally and technically competent professionals who are tasked with representing the legal system, various forms of civilization, and fair geographic distribution[117]. Article 18(1) required the state to report to the UN Secretary-General, at least once every four years, and on committee requests, on the legislative, judicial, administrative, or other measures implemented to operationalize the rights and the progress made. Such a report could list obstacles and variables influencing how well duties are fulfilled[118].

The highest enjoyment of the right to health and equitable access to proper medical care are supported by CEDAW for women. Once more, for Uganda, it is critical to

[116] Supra note 59
[117] Ibid note 62
[118] Supra note 59

determine the state's efficacy in adhering to the CEDAW, as well as its accomplishments and shortcomings. Examining the degree to which the populace has kept an eye on state performance and encouraged it through private endeavors or collaborations, both domestically and globally, is also beneficial.

3.2.4 The convention on the rights of the child (CRC, 1990)[119]

Since a child is at the center of pregnancy, this study also addresses children's right to health. The CRC's preamble begs the state to remember that children require extra protection and care both before and after birth due to their physical and mental immaturity. As a result, this study automatically investigates a child's right to health while assessing the right to mother health.

The CRC's Article 3 establishes that a child's best interests must always come first when making decisions. Article 6 asserts that all children have an intrinsic right to life and requires states to do everything within their power to protect and nurture their children (UN 1990)[120].

Article 24(1) entitles a child to enjoy the highest attainable standard of health and access facilities for treatment of illness and rehabilitation[121].

According to article 24(2), the state is required to fully implement the right by taking appropriate measures to reduce infant and child mortality, provide necessary medical

[119] Convention on the Right of the Child (1990). Available from: https://www.ohchr.org/sites/default/files/Documents/ProfessionalInterest/crc.pdf [Accessed 3 may 2024]
[120] Ibid note 44
[121] Ibid note 45

assistance by emphasizing primary health care development, and combat disease, environmental pollution, and malnutrition using technology, adequate food, and sanitation[122]. The article integrates women by providing proper prenatal health care, sensitizing them on child health and nutrition, the benefits of breastfeeding, hygiene, accident prevention, and family planning.

Additionally, the state is required under article 24(3) and (4) to effectively eradicate customs that are harmful to children's health and to collaborate globally in order to gradually achieve children's health while taking developing nations' needs into account[123]. An illustration of such a practice is early matrimony. All forms of child abuse, including sexual abuse, are prohibited by Articles 19 and 34 of the CRC. The state is also required to take the necessary precautions to shield children from coercion, sexual inducement, exploitation, and use of children in pornographic acts and materials[124]. Is all this from your mind? This is especially important for Uganda, where 25% of girls between the ages of 15 and 19 become pregnant when they are teenagers (UBOS and ICF, 2017), which is a result of early sex initiation.[125].

A child who has been properly placed for care, protection, or treatment of their physical or mental health also has the right to a periodic assessment of the treatment and placement circumstances under article 25 of the CRC. Every child has a right to a standard of living that is sufficient for their physical, mental, spiritual, moral, and

[122] Ibid note 46
[123] Ibid note 47
[124] Supra note 44
[125] Uganda Bureau of Statistics (UBOS) and ICF (2017) 'Uganda Demographic and Health Survey 2016: Key Indicate Others Report,' UBOS, Kampala.

social development under Article 27(1) and (2), which places the primary responsibility for securing the required living conditions—within the limits of their means—on the parent(s) or caregiver[126]. Furthermore, as per article 27(3), the state is tasked with assisting parents and child caretakers with the implementation process by offering material aid and support programs, specifically tailored to their needs and circumstances[127].

Article 42 requires the state to effectively promote public awareness of the CRC's provisions and tenets in order to carry them out. When evaluating the implementation reports, the UN bodies and specialized organizations, such as the United Nations Children's Fund are entitled to representation under Article 45[128]. They and other qualified organizations that may be invited by the committee to offer implementation reports and expert assistance and it also provides them with state reports that include its observations and recommendations along with requests for technical guidance or help. It is evident that Ugandan children's right to health is adequately protected by the CRC[129].

3.2.5 The convention on the rights of persons with Disability[130].

The fundamental tenets of equal opportunity, full and effective participation in society, and nondiscrimination are outlined in Article 3 of the CRPD. While Article 17

[126] Supra note 44
[127] Supra note 44
[128] Supra note 44
[129] Ibid note 53
[130] The Convention on the Rights of Persons with Disability (2008). Available from: https://www.un.org/disabilities/documents/convention/convoptprot-e.pdf [accessed 3 may 2024)

safeguards the bodily and mental integrity of individuals living with disabilities (PWDs), Article 15 forbids torture and cruel, inhuman, or degrading treatment or punishment of PWDs. PWDs have the right to marriage, a family, and parenthood under Article 23, as well as the freedom to use their own family planning methods and maintain their fertility. PWDs are entitled to the best possible level of health under Article 25 and are not to face discrimination of any kind[131].

It requires the state to give people with disabilities (PWDs) equal access to affordable, gender-sensitive health care, insurance, food, hydration, and rehabilitation services that meet the same standards as those provided to other people. Additionally, it mandates that the government offer PWDs services that are specifically designed to meet their needs, such as early diagnosis and interventions to prevent the development of new disabilities[132] (UN, 2007).

Article 4 of the CRPD addresses the implementation issue by requiring the state to guarantee and advance the full fulfillment of PWDs' rights and freedoms via the adoption of suitable legislative and administrative measures as well as through PWD consultation[133].

Article 33 stipulates that the state must select focus areas of government to enforce the rights and duties outlined in the CRPD, thereby facilitating national implementation and oversight. Additionally, the state is tasked with creating,

[131] Ibid note 55
[132] Hendriks, A. (2007). UN Convention on the Rights of Persons with Disabilities. *European Journal of Health Law*, 14(3), 273-298.
[133] Supra note 55

bolstering, or establishing a structure that will encourage and safeguard appropriate project implementation[134].

According to article 35, the state must submit a comprehensive report on its implementation measures and progress to the committee every four years and whenever the committee requests so. This submission must be done through the United Nations Secretary General[135].

The state is urged to prepare the reports in an open and transparent manner by Article 35(4) and (5). Article 36 gives the committee the authority to ask the state for more details on how it is being implemented and to offer broad recommendations, to which the state is not required to reply[136]. Lastly, article 36(4) mandates that the state enable public access to the committee's recommendations and make its reports available to the public[137].

Uganda has not ratified the most recent and updated **ILO Maternity protection convention 183**, (ILO 2000)[138] but it has expanded provisions for maternity protection notably in extending maternity leave to sixty working days (12 weeks) within the **Employment act no.6 of 2006** up from 6 weeks (republic of Uganda,2006). This is still far below the recommended minimum of 14 weeks, but the act provides for paternity leave (for the husband) in the event that the wife has gone through child

[134] Ibid note 57
[135] Supra note 55
[136] Ibid note 59
[137] Supra note 55
[138] Benecke, M. (2018, September). ILO Conventions 3, 103 and 183 on Maternity Protection. In International and European Labour Law (pp. 1365-1370). Nomos Verlagsgesellschaft mbH & Co. KG.

birth or had a miscarriage. Uganda is one of the 29 countries, which had adopted laws that provide an absolute prohibition against the dismissal of a worker during maternity leave for any reason (ILO, 1998).

3.3 Regional instruments and continental and sub-continental level

3.3.1 The African charter on human and people's rights[139]

The ACHPR is the main instrument for protecting human rights in Africa. The African Commission on Human and People's Rights, which was established in 1987 and has its current headquarters in Banjul, Gambia, is responsible for overseeing and interpreting the charter. In 2005, the most recent protocol to the charter went into force. Every person is declared inviolable in Article 4 of the ACHPR due to their inherent right to life and integrity[140].

Article 16 confers on each individual a right to the highest attainable state of physical and mental health. Article 16(1) of the African charter on People's Rights provided that, "every individual has the right to enjoy the highest attainable state of physical and mental health." Article 16(2) obliges state parties to the African charter to take "the necessary measures to protect the health of their people and to ensure that they receive medical treatment when they are sick"[141].

In accordance with international agreements and conventions, Article 18 mandates that the state safeguard women's and children's rights as well as the physical well-

[139] African Charter on Human and Peoples Rights. Available from: https://au.int/sites/default/files/treaties/36390-treaty-0011_-_african_charter_on_human_and_peoples_rights_e.pdf [accessed 3 may 2024]
[140] Ibid note 85
[141] Supra note 63

being of families[142]. This was made clear in the Egyptian initiative for Personal Rights and Interights v. Egypt case, where the African commission determined that Egypt had violated the human rights of four female journalists to equality, non-discrimination, dignity, and freedom from cruel, inhuman, and degrading treatment when it neglected to shield them from state violence and failed to provide them with medical care and forensic examinations during the Taba Bombings interrogations (OAU, 1982).

The ACHPR developed the protocol on the Rights of Women in Africa, which specifically addresses women's rights. Women's health and reproductive rights are protected under Article 14 of the Protocol, which also gives them the ability to decide how many children to have and how far apart to space them. The item also requires the state to build and enhance the current prenatal, postnatal, and nutritional services and programs during pregnancy and lactation[143].

The protocol is there to protect women's reproductive rights by authorizing abortion in cases of sexual assault, rape, incest and where the pregnancy is dangerous to the mother's physical and mental health. Uganda is signatory to this protocol with reservation on this specific article 14(2)c relating to abortion. In addition, article 18 of the protocol provides for a healthy and sustainable environment, which is crucial to the wellbeing of pregnant women and babies[144]

[142] Supra note 63
[143] Supra note 85
[144] Ibid note 65

Article 25 of the African charter addresses rights implementation by obliging the state to use education and accessible publications to promote human rights. Article 26 requires the state to guarantee the independence of courts and support the established and improvement of appropriate national institutions entrusted with the promotion and protection of rights and freedoms[145].

Article 30 established the ACHPR to promote and protect rights, interpret charter provisions and perform other tasks assigned by the Assembly of heads of state as stated in Article 45 (OAU, 1982). As a safeguard, article 61 allows the commission to consider general principles of law, precedence, other international conventions, and international norms and customs accepted as law[146].

Article 62 ensures state accountability by requiring countries to submit a report every two years on the legislative measures taken to implement human rights. This provision has often been considered as being problematic as countries struggle to submit reports in a timely manner. The articles effectiveness largely depends on the citizens active monitoring of its governments actions and of the reports authenticity[147].

Some instruments were specifically created to be applied in east African countries and also include provisions that are relevant to the protection of the right to health in Uganda. Like, article 117 of the treaty for the establishment of the east African community (EAC) obliges the partner states to co-operate in various matters including health. Article 118 enjoins the partner states to promote the management of health

[145] Supra note 63
[146] Ibid note 67
[147] Supra note 63

delivery systems to enhance the efficiency of their health care systems. The treaty further charges the partner states to promote the harmonization of national health policies and regulations, and cooperation in the development of specialized health training, study and reproductive health[148] (EAC, 1999)

Pursuant to articles 118,127,128 and 129 of the treaty, the east African health platform (EAHP) was formed as a collaborative space for representatives of private sector organizations (PSOs), civil society organizations (CSOs), faith Based organizations (FBOs) and other interest groups of east Africa to effectively drive sustainable health and development in the region. The EAHP vision is of a healthy and productive population which enjoys local quality and affordable health care within the region. Efforts made towards bringing this vision into reality are found in projects such as their 5 year maternal infant health strategy aimed at reducing maternal and new-born mortality rates in east Africa by 2020 (ligami,2015)

In short, the international and regional treaties Uganda is involved in greatly emphasize the need of the right to health.[149] They have often encouraged Uganda to make national efforts towards health care services but have yet to create enough pressure on the government for significant positive change to occur.[150] The international community's arrangements to make the right to health a reality across

[148] Ruktanonchai, C. W., et al. (2018). Temporal trends in spatial inequalities of maternal and newborn health services among four east African countries, 1999–2015. *BMC public health,* 18, 1-13.[accessed 17th may 2024]
[149] CHERUD, 2018
[150] Ibid note 81

the globe are essential for its implementation, but must be accompanied by significant local action from nation member states[151]

3.4 The right to health and Uganda law

In 1995, the current constitution was promulgated. It made unseen efforts to recognize human rights and freedoms in Uganda. However, like its predecessors, it ignored several social economic rights such as the right to health, and tucked it in the national objectives and directive principles of state policy which guide policy development and implementation. However, it did not define the standards of enjoying the rights which are justifiable (Uganda constitutional court, 2012). Substantive provisions, such as chapter four, introduced a bill of inherent rights not granted by the state (republic of Uganda, 1995a).

They specifically guarantee the righto life, to a clean and healthy environment as well as freedom from discrimination and torture, but not the right to health. In 2005, the constitution Amendment act was passed and introduced several changes, including article 8A, on national interest, which bolstered the justifiability of the national objectives and directive principles, and article 32(2), which reinforced affirmative action for women.

This section analyses the national Ugandan laws that are applicable to the right to health. It then examines the role of the current constitution in the realization of the right to health, within the broader context of the international and regional laws mentioned in the previous section and which Uganda has domesticated.

[151] Ibid note 82

3.4.1 The 1995 constitution

As stated in article 2 of the constitution, the republic of Uganda's constitution is the ultimate law of the land, and any laws, customs, or cultures that conflict with it are null and void to the degree of their inconsistency (Republic of Uganda 1995a). Since the constitution supersedes all other laws, all health laws must abide by its stipulations or risk being declared invalid. The 1995 constitution introduced a bill of rights, guaranteeing Ugandans their inalienable rights, for the first time in the country's history.[152]

The Ugandan courts had previously held that national objectives were not justifiable, but scholars contend that article 8A now renders them legally binding and enforceable. Nevertheless, the constitution does not expressly stipulate the right to health; rather, it has a number of health-related provisions, which are discussed in the following section. Since 2005, article 8A has required the state to be guided by national objectives and directives of state policy in applying or interpreting the constitution[153].

As a result, court opinions have changed to acknowledge that the government has a negative duty to uphold people's rights and to consider cases in deciding whether or not state affirmative action obligations are met in order to permit the enjoyment of people's rights (Soohoo and Goldberg, 2010)[154]. In the seminal case of David Mugerwa vs. A.G. & others, for example, the court declared unequivocally that the district

[152] The Constitution of the Republic of Uganda, (1995) as amended
[153] Ibid note 73
[154] Cynthia, s et al (2010). The full realization of our rights: the right to health in state constitutions. Available from: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2329904 [accessed 3 may 2024]

hospital had breached the deceased mother's entitlement to basic medical care by neglecting to offer emergency obstetric care[155].

The following provisions serve as the foundation for the requirement that appropriate maternal health care be delivered: objective XIV, which focuses on social and economic objectives; objective XV, which acknowledges the role of women in society; objective XXI, which guarantees access to clean and safe water at all levels; and objective XXII, which guarantees food security and adequate nutrition. The following are some of Uganda's substantive constitutional guarantees of the right to health[156]:

Human rights include those that are inalienable and not bestowed by the state, according to Article 20(1). In particular, all government institutions, agencies, and individuals are required under article 20(2) to protect, promote, and uphold all human rights, particularly those that are related to health[157]. This serves as the foundation for the constitutional right to health's execution, which imposes duties on both public and private duty bearers. Article 21(4), which states that no provision against discrimination may prohibit parliament from passing laws required for the implementation of programs and policies intended to address social imbalances or to provide for any matter that is appropriate and clearly justified in a free and democratic society, serves as further reinforcement of these obligations. There are three responsibilities mentioned below;

[155] Ibid note 75
[156] supra note 73
[157] Supra note 73

The need to uphold human rights is a negative one, meaning that both the state and individuals have a duty to abstain from impeding the exercise of the right to health[158].

The government must create favorable conditions that will enable the realization of the right to health in order to carry out its promotion obligation. Through legislative, administrative, judicial, and financial measures, the right is being pushed further[159].

Lastly, the duty to protect is also affirmative and requires the state to defend the right to health against actions taken by outside parties that violate it. For example, the state is required to regulate the manufacturing of controlled substances, outlaw smoking in public areas, and require compulsory physical elongation in residential elementary schools[160].

Equality before and under the law in all areas of life is guaranteed under Article 21(1). Discrimination on the basis of sex, birth, religion, social or economic status, or handicap is forbidden under Article 21(2) (Article 21(3))[161]. The enjoyment of one's right to health can be impacted by any of those factors, as will be covered in more detail in chapter three. The petitioners successfully contested the legitimacy of portions of the penal code act that criminalized adultery against women but not against men in the case of Law and Advocacy for Women (Uganda) v. Attorney

[158] Ibid note 78
[159] Ibid note 79
[160] Supra note 73
[161] Supra note 73

General.[162] The parts were declared void by the court after it determined that they violated articles 2 and 21 of the constitution and were discriminatory.

Interestingly, anything allowed by the constitution may be applied differently to different groups and in favor of particular groups, according to article 21(5). For example, while the same constitution permits preferential action to be done to increase access to and affordability of health services in remote or impoverished areas, people who live in more privileged locations cannot claim that this remedial action is discriminatory.

Article 22 forbids the wrongful deprivation of any person's right to life, including the life of an unborn child[163]. The outcome of this research is that any death brought about by a deliberate process (such as abortions or executions carried out by a competent judge after a fair trial) needs to be carried out in accordance with a particular law that was established by parliament[164]. The fundamental right to life and health is violated by all other illnesses-related deaths, including maternal and infant mortality.

Parliament has not yet performed its role of passing legislation legalizing abortion in cases when it makes sense. Rather, abortion is illegal under the Penal Code Act's sections 141, 142, 143, and 212, and anybody found to have assisted in an illegal

[162] Uganda Constitutional Court (2010) 'Constitutional Petition No. 8 of 2007, Law & Advocacy for women in Uganda v Attorney General: UGCC 4,' UGCC, Kampala
[163] supra note 73
[164] Musoke, J. T., & Tolboom, B. NEEDS ASSESSMENT ON SAFE ABORTION ADVOCACY.

pregnancy termination, including mothers and medical professionals, faces consequences because they fear being charged with murder, women risk having dangerous and covert abortions without seeking medical attention[165].

However, in order to protect women, article 14(2) of the women's protocol to the ACHPR legalized safe abortion under appropriate circumstances and ordered the state to refrain from punishing or prosecuting women who choose to abort. It also exempted medical professionals from legal action or disciplinary action when they perform abortions and provide post-abortion care (AU 2003)[166].

These circumstances of approved medical abortions include incest, pregnancy resulting from sexual abuse, and situations in which the mother's or the unborn child's health is in jeopardy. The national policy guidelines and service requirements for sexual and reproductive health and rights in Uganda are comparable. 2012 addresses the management of access to and utilization of safe abortion services as well as the prevention of unsafe abortion, acknowledging when a pregnancy poses a risk to life.[167](Mulumba et al.,2017).such cases include severe cardiac or renal disease, preeclampsia, Eclampsia and fetal abnormalities incompatible with extra-uterine life which are also a lawful defense under section 224 of the penal code act (mulumba et al., 2017).

[165] Penal Code Act, cap 120. (1950), sections 141,142, 143 and 212.
[166] African Union (2003) '*Protocol to the African Charter on Human and People's Rights on the Rights Of Women in Africa* (Maputo Protocol Text),' African Union Commission, Addis-Ababa.
[167] Mulumba M, et al (2017) 'Access to safe abortion in Uganda: *Leveraging opportunities through the harm reduction model,*' International Journal of Obstetrics and Gynecology 138(2):231-236

Furthermore, Article 23 forbids depriving someone of their personal freedom unless certain conditions are met, such as the imposition of quarantines to stop the spread of infectious or contagious diseases, the need to care for or treat a child for their welfare, or the need to restrain someone who is reasonably suspected of being mentally ill or addicted to drugs or alcohol in order to protect the community[168]. In this case, the impacted person's right to enjoy their personal liberty is restricted based on the necessity of upholding their right to health. This study demonstrates the intricate interdependencies between human rights by confirming that being in good health is a requirement for exercising other rights.

Article 24 guarantees human dignity and prohibits cruel, inhuman, or humiliating treatment. Even when it comes to health care providers, pregnant women are nevertheless subjected to harsh, brutal, or demeaning treatment in spite of this clause[169]. The petitioner in Joyce Nakacwa v. Attorney General & 2 others[170] gave birth by the side of the road close to Naguru Hospital. After giving birth, she went to the maternity clinic with the baby still attached to finish the process, but she was not given any medical attention and was instead directed to Mulago Hospital without a letter of recommendation. She filed a lawsuit after losing her baby, alleging that the hospital had breached her right to be free from torture and cruel, inhuman, and humiliating treatment by refusing to provide her with a respectable environment to finish the birth process. The court acknowledged that the medical workers omissions

[168] Supra note 73
[169] Ibid note 89
[170]. Uganda Constitutional Court (2002) 'Constitutional Petition No. 2 of 2001 [2002] UGCC, Joyce Nakacwa v Attorney General and Others ((Constitutional Petition No. 2 of 2001)) [2002] , Kampala.

contributed to the death of the child. Nakacwa's case highlights the torturous situations to which pregnant women are confronted to in the health care system (Uganda constitutional court, 2001)

A fair public hearing is guaranteed in Article 28 for all civil and criminal cases before a qualified, unbiased, and independent court or panel[171]. Because the right to health is a civil right and its infringement is punishable by law in both civil and criminal contexts, Ugandan courts have heard more cases involving this right.[172]

Every woman and man of legal age has the right, under Article 31, to freely start a family and to equally benefit from all marital privileges. This clause is especially progressive since it gives women the authority to bargain for and decide how to exercise their sexual and reproductive rights, such as using family planning[173]. Additionally, it gives them the confidence to take an active role in their family's well-being in areas like housing, food, and hygiene without fear of prejudice. In the case of best Kemigisa v Mable Komuntale and another[174], the court found that the Tooro tradition which barred a woman from inheriting property on the basis of her sex was repugnant to the constitution (Bagonza, 2016)[175]. This ruling upheld women's rights to use their property as they see fit and to decide how best to utilize it to pay for high-quality, reasonably priced healthcare.

[171] Supra note 73
[172] CEHURD 2018
[173] CEHURD 2012
[174] Best Kemigisa v Mable Komuntale and another HCCS No.52
[175]Bagonza, AD. (2016). *Post Modernism and Modernism Jurisprudence.* Available from: http://atuhairedavisbagonza.blogspot.com/2016/03/post-modernism-and-modernism-in.html [accessed 3 may 2024]

Article 35 protects persons with disability (PWDs) by entitling them to respect and human dignity, and by requiring that parliament enacts additional protective laws according to their needs. An example of such a law that has yet to be adopted is one that compels all health centers to have ramps or lifts making them accessible for PWDs[176].

In the case of legal action for people with disabilities v attorney general and others[177], the applicants sought a declaration that the respondent's failure to make their premises easily accessible to PWDs violated their fundamental rights (Uganda high court, 2014b)[178]. The court rejected this claim stating that it cannot order a prompt enforcement of the law because of the hardship that such enforcement would entail. This logic is an obvious illustration of the prevailing mindset that prioritizes financial savings over providing PWDs with access to reasonably priced healthcare.

In general, PWDs deal with accessibility issues on a daily basis that are dangerous to the nation's health and have not yet been acknowledged by the courts (CEHURD, 2016). Although the courts have not yet established a generally recognized definition of a minority group in the context of Uganda, article 36, which guarantees the protection of minorities, strengthens articles 32–35.

For any minority who wishes to assert their right to health care, this subjectivity increases the evidentiary burden and standard of proof in the face of broad judicial

[176] Supra note 73
[177] Uganda High Court (2014b) Miscellaneous Cause No. 146 of 2011, Legal Action for People with Disabilities v Attorney General Another: UGHCCD 76,' UGHC, Kampala
[178]Uganda High Court (2014b) Miscellaneous Cause No. 146 of 2011, Legal Action for People with Disabilities v Attorney General and another: UGHCCD 76,' UGHC, Kampala.

discretion to dismiss cases. Therefore, this is yet another issue that needs to be looked into in order to determine what minority rights actually are in Uganda and how specific conditions allow minorities to claim their constitutional right to health.

3.5 National legislation

Uganda has a number of legislation that either completes or addresses some of the gaps in the constitution. The Ugandan parliament is required under Article 79 of the constitution to enact legislation that promotes Uganda's development, peace, order, and good government[179]. Parliament is designated as the principal legislative body by this legislation. Every act that the parliament proposes must be ratified by the president and follow the constitution in order to become law. The protection, fulfillment, and respect of the right to health are the goals of a number of acts. For example;

3.5.1 The Food and Drugs Act cap 278[180]

focuses on preventing food and drug alterations that are unsafe for human consumption and the **water act, cap 152**[181] regulates the management, conservation, and use of water resources. A different class of acts focuses on how the state carries out the constitutional duties of the parliament by creating public agencies that are in charge of health care provision. Among the instances are;

[179] Supra note 73
[180] The Food and Drugs Act cap 1959 (chapter 278)
[181] Water Act 1997 (chapter 152)

3.5.2 The National Medical Store Act, cap 207[182] which created the nation's center for the effective and affordable acquisition of high-quality medical supplies for healthcare services.

3.5.3 The National Drug Policy and Authority Act, Cap 206[183], which established a body to guarantee the supply of affordable and effective medications.

3.5.4 The National Environment Act, Cap 153[184]**,** which, in accordance with article 39 of the constitution, is in charge of managing a clean and healthy environment (republic of Uganda, 1959; 1993a;1993b;1995a; 1995b;1997a)

3.5.5 The Uganda medical and dental practitioner's council (UMDPC) governs the behavior of all dentists and medical professionals (Act, cap. 272). The council has an ethics code that outlines the responsibilities health professionals have when it comes to upholding human rights. **The Uganda nurses and midwives council (UMC)** similarly is regulated by Nurses and midwives Act, cap 274 which require nurses and midwives to protect human rights.

Professionals adhere to ethical principles that establish guidelines for safeguarding human rights. For instance, Rule 4 of the code of ethics for medical and dental professionals mandates that they uphold and defend human rights; however they refer to these duties as ethical responsibilities[185]

[182] National Medical Stores Act 1993 (chapter 207)
[183] National Drug policy and Authority Act 1993 (chapter 206)
[184] The National Environmental Act 1995 (chapter 153)
[185] Orbinski, J., Beyrer, C., & Singh, S. (2007). Violations of human rights: health practitioners as witnesses. The Lancet, 370(9588), 698-704.[Accessed on 17th may 2024]

3.6 Summary of findings

The section examined the international, regional, and national legal frameworks that have an impact on Uganda's constitutional right.

Conclusion

When examining the legal issues surrounding barriers to healthcare access in Uganda, several key factors come into play and this is mostly the conventions like the convention on the rights of the child, we also have the constitution of the republic of Uganda, the public health act and many others. However, despite these legal frameworks, challenges such as limited resources, inadequate infrastructure and many others hinder access to care for many individuals hence addressing these legal issues and implementing effective policies is crucial to overcoming barriers and ensuring equal access to healthcare for all Ugandans.

4.0 Chapter four

4.1 SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

4.1.1 INTRODUCTION

This chapter contains the information that was gathered during the research process and an analysis on the data that was gathered. The researcher examined the barriers to health care access in Uganda; the challenges faced in the making sure these barriers are curbed and some recommendations on how to advance the right to health.

4.2 SUMMARY OF FINDINGS

These barriers to healthcare access and the right to health have been enshrined in a number of international and regional treaties to which Uganda is a signatory. And it therefore imposes an obligation on them to make every possible effort to protect, fulfill, respect and promote the right to health of their citizens.

In the process of the research, the researcher found that there are various aspects that have a bearing on the right to health which include among others;

4.2.1 Legal framework and enforcement

Even while the legal system offers both criminal and civil law remedies for medical negligence, it is insufficient to hold the professional accountable for their actions and to force the government to pay damages.

Additionally, as stated in article no. 52 (1) of the 1995 constitution[186], the UHRC is tasked with looking into human rights violations on its own initiative or in response to a complaint from any individual or group. It also monitors government compliance with international human rights agreements and advises parliament on effective measures to ensure the respect of human rights violations.

Nevertheless, an examination of its operations reveals that even while the organization gets a lot of complaints, it lacks the funding and staff to respond to them quickly. Furthermore, the majority of state actors against whom orders of compliance are filed either delay or completely disregard the orders when the complaints are handled, depriving the claimants of their compensation[187] (Bakayana, 2006). Therefore, even while the UHRCR's work is crucial to the advancement of the right to health, there are insufficient enforcement mechanisms to support its ability to effect change and address violations through its surveillance mandate.

4.2.2 Political will

The government has stated that it is politically willing to develop and implement laws that promote the realization of the right to health as a component of the constitution[188]. The executive has developed administrative policies that support the political application of the constitution. The human rights based approach (HRBA),

[186] The Constitution of the Republic of Uganda, 1995 as amended
[187] Bakayana, I. (2006). *From protection to violation*? Analyzing the right to a speedy trial at the Uganda Human Rights Commission. Available from: https://www.asclibrary.nl/docs/373734425.pdf [Accessed 17th may 2024]
[188] Soohoo, C., & Goldberg, J. (2009). The full realization of our rights: The right to health in state constitutions. Case W. Res. L. Rev., 60, 997. Available from: https://scholarlycommons.law.case.edu/cgi/viewcontent.cgi?article=1341&context=caselrev [accessed on 17th may 2024].

which has established many techniques to enable the state to fulfill its commitments in the health sector, is an example of such an endeavor.

Uganda Vision 2040, which gives guidance to all governmental activities aimed at the fulfillment of its tasks and obligations, including the provision of healthcare, serves as the executive's guide[189] (National Planning Authority, 2013). For Uganda's human rights campaigners, the framework's recognition of the state's duty to uphold and advance human rights is crucial. In order to improve government officials' ability to uphold and defend human rights, it also binds the government to making sure that human rights-based approaches (HRBA) are included into laws, policies, and programs.

In addition, Vision 2040 criticizes Uganda's health sector's sluggish growth and ties it to the country's current facility-based service delivery system, emphasizing the importance of excellent health to a society's socioeconomic transformation. Therefore, it advocates for a paradigm change toward a system of household-based health service delivery that would support healthy lifestyle choices and habits to enable families and communities to take charge of their own health.

Ten-year development plans make up the vision's execution plan. The second national development plan (NDP II), which covers the years 2010–2020, is presently being implemented in Uganda (National Planning Authority, 2015). By guaranteeing that

[189] Matte, R. (2017). Bureaucratic structures and organizational performance: A comparative study of Kampala capital city authority and national planning authority. Journal of Public Administration and Policy Research, 9(1), 1-16. Available from: https://academicjournals.org/journal/JPAPR/article-full-text-pdf/43C64DF62435.pdf [accessed 17th May, 2024]

every Ugandan has access to high-quality healthcare, NDP II aims to realize the goals of Vision 2040[190].

It has established a number of goals that must be met in order to do this. For instance, by 2020, it hopes to lower the ratio of maternal deaths occurring outside of hospitals from 148/100,000 to 119/100,000, raise the proportion of child deliveries carried out in hospitals from 41% to 64%, and lower the ratio of deaths involving children under the age of five from 18/1000 to 16/1000. The goals of NPD I, which primarily focused on ending poverty are expanded upon in this plan. The primary way that NDP II varies from the last plan is that it places more of a focus on the role that public-private partnerships play in the supply of private healthcare and amenities (National Planning Authority, 2015)[191].

4.2.3 Monitoring and evaluation mechanisms

Although there are many laws and policies pertaining to the right to health, the majority of them lack explicit procedures for keeping track of how well duty bearers are performing and how to hold them accountable. With the exception of professional regulations, the majority of laws and policies focus monitoring on private sector entities and individual individuals rather than the state, which is the principal responsibility bearer. The majority of monitoring mechanisms are outlined in the subsidiary legislation[192].

[190] Second national development plan (NDP II) 2015
[191] Ibid note 105
[192] Calland, R., & Bentley, K. (2013). The impact and effectiveness of transparency and accountability initiatives: Freedom of information. Development policy review, 31, s69-s87.Available from:

For example, the majorities of regulations require health service providers to submit operational or compliance reports and conduct inspections. Furthermore, they give the regulators the power to seize equipment, close medical institutions, or levy punitive fines in any way they see suitable. Patients thus lose access to essential medical treatment, particularly in the isolated locations where medical service providers invest little in line with the level of growth in rural areas[193].

Government health organizations, on the other hand, rely on administrative procedures to ensure that they are meeting their responsibilities under the right to health. Examples of this type of work include periodic or distributed reviews of policies and budgets, audits, both internal and external, evaluations of projects, and impact analyses. Given that the monitoring is carried out either internally or by individuals under contract from the same state agency, it is possible that performance reviews will be lenient[194].

Furthermore, while private actors may face harsh repercussions for their misdeeds, public institutions are not always required to follow suit. Such a double standard needs to be addressed since the state has the primary responsibility for preserving, advancing, and safeguarding the right to health.

4.2.4 Culture

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https://onlinelibrary.wiley.com/doi/pdf/10.1111/dpr.12020?casa_token=Vdx5s6M3A_0AAAAA:Quahrpoljtbm2-hAEdY28FhRzYhjOJ1JnWKPKcsgaEyZ59F3gKgFTYo9Gj4K8mWghPHUWJScdCrQPWA [accessed 17th may 2024]

[193] Ibid note 7

[194] Ibid note 8

Lifestyle decisions, particularly those related to health, are also heavily influenced by culture both positively and negatively. Health trends showed that, in accordance with their culture, women select, use, and obtain particular health services, whether conventional or professional. Regrettably, due to a number of cultural customs, including the community's support of traditional births, the high expense of professional medical care and traditional misconceptions about health care, Ugandans are unable to fully utilize modern health care services.

4.3 Challenges

4.3.1 Lack of political will

It is important to remember that Uganda lacks national legislation on the right to health, despite the fact that the constitution has a detailed bill of rights in chapter four. Nevertheless, there are a few policies and methods for mainstreaming human rights in healthcare.

4.3.2 Outdated laws

Although the parliament must pass legislation to maintain Uganda's order and promote good governance, the country does not yet have a comprehensive health law. Rather, there are several laws covering different facets of health. Some of them date back to the colonial era, when the current constitution was drafted. Over time, countless scientific and technical advancement have rendered many of them outdated. This includes the Mental Treatment Act of 1938, the Public Health Act of 1935, and the Venereal Diseases Act of 1977, as previously mentioned. Fortunately, the Public Health Act is being reviewed, but it will take some time.

4.3.3 Ignorance

The great majority of people in the general public and healthcare professionals are ignorant of the right to health. The laws and policy frameworks that support and uphold the right to health, the acceptable course of action to follow, and the proper place to seek redress in the event of a violation are unfamiliar to a large portion of Ugandans. In addition, the health professionals are not well trained in this area, which leads to programs and policies that do not fully incorporate human rights.

4.3.4 Inadequate institutional support

Whereas Uganda is a signatory to various international instruments that pertain to the right the health, there has been a failure to implement this right meaningfully at a national level. It cannot be overemphasized that Uganda does not give appropriate acknowledgment of the right to health through a complete piece of law and policies that put in place an institutional system that promotes the implementation of the aforementioned right.

4.3.5 Inadequate financing to the ministry of health

Less than 8% of Uganda's yearly budget is devoted to health, indicating that the country does not prioritize money for health (Africa Health Observatory, undated). Because of this, hospitals are typically understaffed, have inadequate medical supplies, and pay their employees badly. As was previously mentioned, these topics were a topic of public discussion during the strikes by healthcare professionals. Increased financial commitments to the health sector and its allocation in accordance

to health requirements are necessary for the Ugandan health care system to improve, maternal mortality to drop, and the realization of the right to health.

4.3.6 Gender related inequalities

These put women at danger and impede their ability to truly realize their right to health. This has translated into high mortality rates which originate from poor sexual and reproductive care, family planning and other associated concerns.

4.4 Conclusions

While the right to health care access is of great importance in Uganda, it has not been largely recognized in Uganda as to the reasons listed above.

This research leads to the conclusion that despite having various political commitments, member states have a long way to go towards the full realization of the right to healthcare access in Uganda.

In regards to the challenges highlighted above, the researcher has suggested some recommendations whose implementation he trusts can increase the public's perception of the right to access health care services and provide the various stakeholders with the necessary information to encourage its protection and enforcement as a guaranteed right.

4.5 Recommendations

The researcher advocates that government and other stakeholders implement programs for capacity building, review of outdated laws, formulation of regulations

and sensitization of the populace among other strategic interventions that are traversed herein;

The government of Uganda is motivated to review its legislations and policies to assess their consistence with human rights standard and put in place institutional mechanisms and enough resources that will ensure their implementation, enforcement and monitoring.

Uganda should also implement the primary health care, and the minimum essential complements of the right to health should be defined. These include equitable access to and supply of health facilities, services, and goods; maternal and child health services; access to health-related education and information; and the availability of health personnel with the necessary training.

When developing strategies for the health sector and other national programs, the government should systematically incorporate a gender-based approach.

A participatory process can also be adopted by the government and in conformity with human rights principles identify multi-sectorial collaboration mechanisms between all relevant government ministries and parliamentary committees and civil society organizations where they do exist to identify and address the specific health care needs of vulnerable and marginalized populations, increase the public awareness of this right and monitor its implantation.

The central government's role should be restricted to policy formulation and technical guidance with delivery of services left to the private sector and authorities.

Government should also build and provide more health centers at sub-county level so as to bring the health services closer to the people and enable them to attain their right to health care access.

The government should also regulate the health sector by setting the minimum and maximum charges for the services offered in private health facilities to avoid exploitation of the patients that go there to seek better services.

Wedges and salaries of the health workers should be enhanced so that they are prompted to offer proper services to the patients thus promoting their right to access healthcare.

The Ministry of Health could create an effective system at a reasonable cost if the government strengthened the current systems and mobilized local resources to streamline referral mechanisms. These could involve overseeing and growing the system to cover other illnesses and fully develop Uganda's healthcare system, among other things. Uganda will be able to develop a system that is sustainable by making full use of its own resources.

Encouraging community financing schemes known as health equity funds in the rural communities so as to enable poor persons to have access to better health services such that they can achieve their right to access health care services can also help.

CONCLUSION

Here below is a brief overview of what “an analysis on the barriers of health care access” conclusively says; where in Uganda, there are various barriers to health care access. Some of the national frame works in place aim to address these challenges and also the international conventions also play a role in advocating for improved health care access.

However, there are still challenges that need to be overcome, such as inadequate infrastructure, limited resources, and many other barriers, additionally; socio-economic factors, cultural beliefs, and gender disparities can further impact access to health care.

To improve healthcare access, some recommendations include increasing investment in healthcare infrastructure, expanding health care services to rural areas, and addressing social-economic and cultural factors that hinder access.

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