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COVID-19 & THE RIGHT TO HEALTH IN UGANDA

Analysis of the national response and its implications for the realization of the the right to health

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COVID-19 & THE RIGHT TO HEALTH IN UGANDA

ANALYSIS OF THE NATIONAL RESPONSE AND ITS IMPLICATIONS FOR THE THE REALIZATION OF THE THE RIGHT TO HEALTH

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Table of Contents

Executive Summary

COVID-19 is a public health, gender, human rights and development issue. The virus has spread widely and caused concern and disruption globally and nationally. It is a highly infectious disease caused by the corona virus and spread from person to person through sneezing and coughing droplets.

Uganda is a party to international and regional human rights instruments that oblige it to respect, protect and fulfill the right to health. It also has a Constitution that obliges it to respect and uphold human rights generally and the right to health in particular. However, these human rights may be threatened by the COVID-19 response. Against this backdrop, this technical brief seeks to answer the following questions:

- What are the implications of the COVID-19 response for the realization of the right to health in Uganda?
- How should government of Uganda ensure that the COVID-19 response does not undermine realization of the right to health?
- What role should civil society organizations (CSCOs) play in the struggle to realize the right to health amidst the COVID-19 response?

The technical brief concludes that human rights generally and the right to health in particular, have been or will be adversely affected by the COVID-19 response.

Any deprivation of enjoyment of human rights should be in public interest and ought to be demonstrably justifiable. However, government should ensure that the public health measures in question are implemented without unduly burdening human rights. Human rights, including the right to health, should be at the centre of the COVID-19 response. Human rights should guide all efforts to tackle the pandemic, including ensuring participation by all affected communities in all response measures. There should be a concerted effort by the government, in collaboration with non-governmental actors, in tackling the pandemic.

- **Government should:** ensure there is no limitation or derogation of minimum core components of the right to health; mobilize and deploy resources; ensure participation of stakeholders in the COVID-19 response; ensure free flow of information; take steps to combat all forms of stigma and discrimination associated with the response; ensure periodic review of the response; observe ethics, including confidentiality and free, prior informed consent; support and protect health workers involved in the fight against the pandemic; not 'politicize' the fight against the pandemic; actively involve the private sector, including Civil Society Organizations (CSOs) in the fight; hold all agencies in the response accountable for any violations of human rights and the right to health in particular; and ensure that a declaration of a state of emergency is the last resort.

- **CSOs should:** lobby and engage responsible authorities so that they are actively engaged in the response; be proactive and innovative in devising strategies that supplement government's efforts; and hold virtual meetings among themselves to chart a forward.

1. Introduction.

COVID-19 is a public health, gender, human rights and development issue (Wenhan et al, 2020). It has spread widely and caused concern and disruption globally and nationally. COVID-19 is a highly infectious disease caused by the corona virus and spread from person to person through sneezing and coughing droplets. It can also spread when a person touches a contaminated surface and then touches their eyes, nose and or mouth. Globally, over 2,500,000 people are infected with the corona virus whilst the death toll has surpassed 180,000 and numbers continue to rise (Worldometer, 2020).

At the time of writing this brief, in Africa there was over 25,000 virus infections. In Uganda, by 22 April 2020, 61 people had tested positive for the corona virus with no deaths reported. There is neither a vaccine nor cure for COVID-19, but there is supportive treatment for most of the patients who are symptomatic.

On 11 March 2020, the World Health Organization (WHO) declared COVID-19 a pandemic and enjoined governments to take urgent action to tame its spread (Human Rights Watch, 2020). The pandemic has been correctly referred to as 'a global public health crisis that is unprecedented during at least the past century' (Hogdson & Seiderman, 2020). It will also have a tremendous impact on the 2030 Agenda for Sustainable Development (Teru Avafia et al, 2020).

Uganda is a state party to international and regional human rights instruments that recognize the right to the highest attainable standard of health ('the right to health') and outline the obligations of the government towards realization of this right,

Examples of these instrumental include:

- The WHO Constitution;
- The WHO International Health Regulations (IHR);
- International Covenant on Economic, Social and Cultural Rights (ICESR);
- The Convention on the Elimination of all forms of Discrimination against Women (CEDAW);
- Convention on the Rights of Persons with Disabilities (CRPD);
- Convention on the Rights of the Child (CRC);
- African Charter on Human and Peoples' Rights (ACHPR); and
- Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa (Maputo Protocol).

The Constitution of the Republic of Uganda also recognizes various components of the right to health such as;

a. Access to health services (objective XIV), including medical services (objective XX);
b. Access to water and sanitation (objective XIV);and
c. The right to a clean and healthy environment (article 39).

The Constitution also recognizes the right to health under those rights and freedoms that are not explicitly mentioned in Chapter Four (article 45).

Most human rights generally and the right to health in particular are under threat as a result of the COVID-19 response. The IHR (2005) enjoin governments to ensure that in the implementation of any public health response to tackle the spread of disease such as COVID-19 pandemic, they fully respect the dignity, human rights and fundamental freedoms of persons (article 3(1)). They should be guided by the Charter of the United Nations and the Constitution of the WHO (article 3(2)).

Against this backdrop, this technical brief paper seeks to answer the following questions:

1. What are the implications of the COVID-19 response for the realization of the right to health in Uganda?
2. How should government of Uganda ensure that the COVID-19 response does not undermine realization of the right to health?
3. What role should civil society organizations (CSCOs) play in the struggle to realize the right to health amidst the COVID-19 response?

In order to properly contextualize the discussion, I commence with a bird's eye view of the right to health and attendant government obligations towards realization of the right.

2. The Right to Health.

The 1946 World Health Organization (WHO) Constitution recognizes the 'enjoyment of the highest attainable standard of health' (preamble) as 'one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition' (preamble). The WHO World Health Assembly adopted the IHR (2005), whose purpose and scope are 'to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade' (article 2).

The UDHR recognizes the right to an adequate standard of living, whose components are critical for the realization of the right to health amidst the COVID-19 crisis and provides that '[m]otherhood and childhood are entitled to special care and assistance' (article 25(2)).

The ICESCR recognizes 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (article 12(1)).

The CEDAW also enjoins states parties to take appropriate steps to eliminate discrimination against women in the field of health care in order to enable them access health services, including those related to family planning (article 12 (1)).

States parties should also ensure that rural women 'have access to adequate health care services, including information, counselling and services in family planning' (article 14(2)).

The CRPD, also guarantees persons with disabilities 'the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of liability' (article 25).

The CRC, recognizes the 'right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health' (article 24(1)).

The ACHPR, guarantees every person 'the right to the enjoyment of the best attainable state of physical and mental health' (article 16(1)).

States parties are enjoined to 'take the necessary measures to protect the health of their people and to ensure they receive medical attention when they are sick' (article 16(2)).

The African Charter on the Rights and Welfare of the African Child, guarantees every child 'the right to enjoy the best attainable state of physical, mental and spiritual health' (article 14(1)).

The Maputo Protocol, obliges states parties to ensure that 'the right to health of women, including sexual and reproductive health, is respected and promoted' (article 14(1)).

The Committee on Economic, Social and Cultural Rights (CESCR) has, in General Comment No 14, emphasized that '[h]ealth is a fundamental right indispensable for the exercise of other human rights' (para. 1). According to the CESCR, the right to health is 'closely related to and dependent on realization of other human rights' (para.

3), including, work, food, housing, education, human dignity, life, equality and non-discrimination, prohibition against torture, and freedoms of association, assembly and movement (para. 3). The CESCR further observes that the right to health should not be misunderstood as 'the right to be healthy' (para. 8) and it 'contains both freedoms and entitlements' (para. 8). The right to health is 'an inclusive right extending not only to timely and appropriate health care, but also to the underlying determinants of health' (para. 11). Such determinants include, 'access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, health occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health' (para. 11) and 'participation of the population in all health-related decision-making' (para. 11).

According to the CESCR, the right to health contains a number of interrelated and essential elements. These include the right to public health-care facilities, goods and services, which should be available in sufficient quantity; and accessible physically and economically without discrimination (para. 12). The right to health also includes the right of access to information about health-care facilities, goods and services, which includes 'the right to seek, receive and impart information and ideas concerning health issues' (para. 12). The right to health also requires that health care facilities, goods and services 'must be respectful of medical ethics and culturally appropriate' (para. 12), and must be 'scientifically and medically appropriate and of good quality' (para. 12).

The ICESCR outlines steps that states should take in order to achieve the full realization of the right to health. The steps, which must be concrete and targeted, include:

a. Provision for the reduction of the still birth-rate and of infant mortality and for the healthy development of the child;
b. Improvement of all aspects of environmental and industrial hygiene;
c. Prevention, treatment and control of epidemic, occupational and other diseases;
d. Creation of conditions which would assure to all medical service and medical attention in the event of sickness (article 12 (2)(a)-(d)).

The CESCR has elaborated on these steps and interpreted article 12(2)(a) as entailing the 'right to maternal, child and reproductive health' (para. 14), which requires 'measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre-and post-natal care, emergency obstetric services and access to information, as well as resources to act on that information' (para. 14). Article 12(2)(b) connotes the 'right to healthy natural and workplace environments', and comprises, among others, 'preventive measures in respect of occupational accidents and diseases; the requirement to ensure an adequate supply of safe and potable water and basic sanitation' (para. 15) and 'also embraces adequate housing and safe and hygienic working conditions, an adequate supply of food and proper nutrition' (para. 15).

Article 12(2)(c) connotes the 'right to prevention, treatment and control of diseases' and this 'requires the establishment of prevention and education programmes for behaviour related concerns' (para. 16) such as COVID-19 pandemic. The right to treatment, includes 'creation of a system of medical care in cases of epidemics [and pandemics such as the COVID-19] and similar health hazards, the provision of disaster-relief and humanitarian assistance in emergency situations' (para. 16).

Article 12(2)(d) entails the 'right to health facilities, goods and services', which includes 'the provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education' (para. 17). It also requires 'regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care' (para. 17).

3. Obligations of Government of Uganda

States parties, including Uganda, have an obligation to progressively realize the right to health to the maximum level of available resources (article 2, ICESCR). However, as the CESCR observed, states parties have obligations of immediate effect: 'to guarantee that the right will be exercised without discrimination' (para. 30); and to take deliberate, concrete and targeted steps towards full realization of the right (para. 30). The CESCR also stresses that the standard of progressive realization does not deprive the states parties' obligations of meaningful content (para. 31).

States parties 'have a specific and continuing obligation to move as expeditiously and effectively as possible' towards full realization of the right to health (para. 31). Retrogressive measures in relation to the right to health are not permissible except where a state party proves that 'they have been introduced after the most careful consideration of all alternatives and that they are duly justified' in light of 'full use of the state party's maximum available resources' (para. 32).

The States parties have obligations to respect, protect and fulfill the right to health. The obligation to respect requires 'states to refrain from interfering directly or indirectly with enjoyment of the right to health' (para. 33).

The obligation to protect requires the 'State to take measures that prevent third parties from interfering' (para. 33) with the enjoyment of the right whilst the obligation to fulfill requires 'states to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health' (para. 33).

The obligation to fulfill also requires the state to facilitate and provide individuals and groups who are unable for reasons beyond their control [for example because of the COVID-19 response], to realize the right by means at their disposal.

According to the CESCR, there are 'core obligations to ensure satisfaction of, at the very least, minimum essential levels of' (para. 43) the right to health, including essential health care, even during the implementation of a public health emergency such as COVID-19.

These core obligations are to:

a. Ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;
b. Ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
c. Ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
d. Provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs; and e) ensure equitable distribution of all health facilities, goods and services (para. 43).

According to the CESCR, there are other obligations that are of comparable priority and they include, to: ensure reproductive, maternal (prenatal as well as post-natal) and child care; provide immunization against the major infectious diseases; take measures to prevent, treat ad control epidemic and endemic diseases [and pandemics]; promote education and access to information; and provide appropriate training for health personnel, including education on health and human rights (para. 44(a)-(e)).

The IHR enjoins States parties to designate or establish a National IHR Focal Point for the implementation of any measures taken to tackle the spread of disease (article 4(1)).

The responsible authorities should strengthen and maintain capacity to detect, assess, notify and report events concerning the disease (article 5(1)).

The WHO is obliged to assist States parties, upon request, to develop, strengthen and maintain capacities to tackle disease (article 5(3)).

A state party is enjoined to notify WHO of all events that 'may constitute a public health emergency of international concern within its territory' (article 6). States

parties are obliged to treat travelers with respect for their dignity, human rights and fundamental freedoms while implementing public health measures (article 32).

4. Implications of the COVID-19 Response for Realization of the Right to health

4.1 The COVID-19 Response

In response to the COVID-19 pandemic, government raised public awareness about the pandemic, by disseminating information through the media on how people should behave in order not to escalate the spread of the virus. Government has encouraged social or physical distancing, washing hands with soap, use of alcohol-based sanitizers, avoiding touching the eyes, nose and mouth, and avoiding spitting in public. Government has, through subsidiary legislation, also put in place a number of drastic public health measures, including, quarantine, self-isolation, travel bans, lockdown, restricted movement, assembly and association. Other measures include, temporary ban on religious activities, and temporary closure of schools and institutions of higher learning and curfew.

The Minister of Health has issued the Public Health, (Prohibition of Entry into Uganda) Order, 2020); Public Health (Prevention of COVID-19); Public Health (Prevention of COVID-19) (Requirements and Conditions of Entry into Uganda) Order, 2020; Public Health (Notification of COVID-19) Order 2020; and Public Health (Control of COVID-19) (No. 2) Rules, 2020).

4.1.1 Quarantine and Isolation

These are public health measures used to protect the public by preventing exposure to people that have or may have a contagious or infectious disease (IHR, 2005; Giubilini et al, 2018; CDC, 2020).). Quarantine separates and restricts the movement of people that were exposed to the disease in order to see whether they fall sick. These people may have been exposed to the disease and do not know it, or they may have the disease but do not show the symptoms. Isolation separates people with a contagious disease from people who are not sick. According to IHR (2005), quarantine means, 'the restriction of activities and/or separation from others of suspect persons who are not ill or suspect baggage, containers, conveyance or goods in such a manner as to prevent the possible spread of infection or contamination' (article 1). The IHR (2005) define isolation as 'separation of ill or contaminated persons or affected baggage, containers, conveyances, goods or postal parcels from others in such a manner as to prevent the spread of infection or contamination' (article 1).

According to the WHO (2020), quarantine measures should be introduced early in the outbreak in order to delay the peak of an epidemic in areas where local transmission is ongoing or both. However, quarantine measures should be properly implemented to avoid creating additional sources of contamination and spread of the disease (WHO, 2020).

WHO advises authorities to ensure that the quarantine setting is appropriate and that adequate food, water, and hygienic provisions are made during the quarantine period. Quarantine places should have adequate ventilation, spacious rooms with hand hygiene and toilet facilities. Medical assistance should also be provided for quarantine travelers who are isolated or subject to medical examinations or other procedures for public health purposes. The authorities should ensure that there is communication with family members who are outside the quarantine facility and if possible, there should be access to the internet, news and entertainment. Authorities should also provide psychosocial support and pay special attention to older persons and those with comorbid conditions because of their increased risk for severe COVI-19 (WHO,

2020). The WHO advise if implemented will lead to the realization of the right to health amidst the COVID-19 crisis.

4.1.2 Lockdown

Like most countries in the world, government has imposed a lockdown all over the country whereby bars, non-food selling shops and schools have been closed. Public and private transport (cars and boda boda) have also been banned except pick-ups and trucks and those engaged in essential services. All people have been required or encouraged to stay at home to avoid catching or spreading the pandemic. Lockdowns have been hailed as an effective preventive strategy (World Economic Forum, 2020) and they aim at reducing reproduction, that is, reducing the number of people each confirmed case infects (Imperial College, 2020). In addition to the lockdown, government imposed a curfew, which is being enforced by the Uganda Police Force (UPF), supported by the Uganda Peoples' Defence Forces (UPDF), the Local Defence Force (LDU) and other security agencies.

5. Implications of the COVID-19 Response for the Right to Health.

The COVID-19 response was designed and is being implemented by the government in good faith in order to control the spread of the pandemic and ultimately promote realization of the right to health. The COVID-19 associated mortalities and morbidities that were reported in China, Europe and the United States and the rapid spread of the pandemic in Africa necessitated a timely and appropriate response from the government as evidenced by the drastic public health measures. In any case, the IHR (2005) recognize the sovereign right of States parties 'to legislate and to implement legislation in pursuance of their health policies' (article 3(4)).

Public health measures to tackle COVID-19 have serious implications for the realization of the right to health. The right to health is interrelated with other rights and freedoms and moves beyond access to health to encompass the social or underlying determinants of health. These include restricted movement, worship, assembly and association, access to medical care, food and nutrition, safe and healthy environment, clothing, shelter, and access to information. These rights and freedoms may be adversely impacted by the COVI-19 response.

Apart from a few media reports that I refer to below, it would be speculative to conclude the extent the right to health is being realized by the people whilst they are in quarantine or isolation or under lockdown or curfew. This may require an empirical investigation, which, unfortunately cannot be undertaken because of the lockdown.

However, suffice to say that the COVID-19 response may lead to a number of violations of health-related rights. The lock down has led to loss of employment especially in the informal sector where those who live 'hand to mouth' and lack disposal income do not have money to spend on health care. It is heartening to note that government, through the Prime Minister's office, has been distributing food such as maize flour, beans, salt and milk to vulnerable communities. Lack of or limited access to and affordability of care especially by marginalized and vulnerable groups such as pregnant women, the urban and rural poor, persons with disabilities, older persons, refugees and other migrants and children may also be a challenge.

With the ban on public and private transport, it is inconceivable how these groups can access timely and appropriate care, including emergency care. These groups may also lack access to adequate food and nutrition, safe water and sanitation, clothing and shelter. There may also be increased incidences of stigma and discrimination against persons infected with the corona virus or those who have been discharged where communities may suspect them to be carriers of the disease. There may also be violation of human dignity through for example torture by enforcement officers (Ephraim Kasozi, 2020; Franklin Daku, 2020; Alex Ashaba & Joseph Omolo, 2020) and sexual and gender-based violence, including domestic violence.

The physical and mental health consequences of torture and domestic violence are dire. There may also be increased cases of mental illnesses such as anxiety, depression and even suicide due to confinement at home especially without disposal income. The desperation of the vulnerable can be seen over defiance of the curfew (Stuart Yiga, 2020), where perhaps they were arrested why returning from looking for livelihood and survival.

The confidentiality and privacy of the infected or those most at risk may also not be guaranteed. We only rely on information delivered by the authorities and hope that it is clear and accurate. We also hope that free, genuine, prior informed consent and pre-and post-testing counselling procedures are observed. Health care workers may also lack protective gear, thereby exposing them to the risk of COVID-19. They may also lack vehicle stickers to enable them attend to their patients (Cecilia Okoth, 2020).

6. What Should Government Do?

6.1. Limitation of Rights is Permissible

Before exploring what government can do, let me point out one fact: Human rights, including the right to health may be limited or restricted on grounds of public interest, which includes public health (Twinomugisha, 2015).

> However, according to the UN Siracusa Principles, any limitation or derogation must be provided for and carried out in accordance with the law; it must be to further a legitimate objective of general interest; it must not impair the democratic functioning of the society; it must not be imposed arbitrarily or in a discriminatory manner; and it must represent the least restrictive means needed to reach the stated goal (UN ECOSOC, 1985).

Under the Constitution of the Republic of Uganda, there are only three human rights and freedoms, which should not be derogated from even in times of emergency. They are: freedom from torture and cruel, inhuman and degrading treatment or punishment; freedom from slavery or servitude; the right to fair hearing; and the right to an order of habeas corpus (article 44(a)-(d)). Apart from these, all human rights and freedoms, including health related rights, may be limited or derogated from on ground of public interest (article 43(2), which includes protection of the public health.

The Constitution is clear: In the enjoyment of his or her rights and freedoms, 'no person shall prejudice the fundamental or other human rights and freedoms of others or the public interest' (article 43(1)). For example, a person who has tested positive for the corona virus cannot argue that through quarantine or isolation, his right to liberty has been violated. His rights to liberty and movement may be restricted because failure to do so may lead to transmission of COVID-19 to others, who may die, thus denying them the right to life.

In any case, a person can be deprived of the right to liberty 'for the purpose of preventing the spread of an infectious or contagious disease' (article 23(d)). According to the Constitution, public interest shall not permit 'any limitation of the enjoyment of the rights and freedoms' that is 'beyond what is acceptable and demonstrable justifiable in a free and democratic society, or what is provided in this Constitution' (article 43(2)(c)). Thus, apart from article 44 rights and freedoms, all rights and freedoms under the Constitution can be limited or restricted for purposes of achieving a set public goal, in this context, preventing the spread of a COVID-19, provided the criteria in the Siracusa Principles and article 43(2)(c), which were expounded upon by Justice Mulenga, JSC, in Charles Onyango Obbo and another v Attorney General (Constitutional Appeal No. 2 of 2002), are met.

6.2. Core Obligations are Non-derogable

In spite of the limitations permitted above, government should ensure that the COVID-19 response does not unduly burden critical human rights meant for livelihood and survival of its citizens, especially the marginalized and vulnerable. Human rights, such as the right to health, whose denial may result in loss of life, must be placed at the centre of any COVID-19 response. In fact, according to the CESCR, the minimum core obligations and rights accruing therefrom are non-derogable.

The CESCR states that, 'a State party cannot, under any circumstances (including COVID-response), whatever, justify its non-compliance with the core obligations set out in paragraph 43, which are non-derogable' (para. 47).Thus, the government must devise modalities to ensure that vulnerable groups such as pregnant women, persons living with HIV/AIDS (PLHV), persons with disabilities, children, older persons, refugees and other migrants, access health facilities, goods and services and essential food that is nutritionally adequate and safe. The government should also ensure that these groups access an adequate supply of safe and potable water and sanitation. It is good that government has established a programme of distributing food to the poor and vulnerable. This food distribution programme should be expanded and enhanced in order to reach all vulnerable people beyond urban areas.

Working with CSOs, including grassroots organizations, government can, through the Local Councils (LCs), issue special permits or stickers for these vulnerable groups to access health care facilities, goods and services. For example, each LC may identify specific vehicles, boda boda or bicycles in the villages (urban or rural) that can be issued with special permits to transport pregnant women in need of critical maternal health care services such as labour and delivery care. Government should also ensure that there is an adequate supply of health care goods and services for PLHV, especially antiretrovirals (ARVs) and drugs for opportunistic infections like Tuberculosis (TB).

Government should ensure that people living in slums, other informal settlements and water stressed areas have access to safe and potable water not only for cooking and drinking but also for washing their hands as a COVID-19 prevention strategy. Government should, after containing the pandemic, construct boreholes or pull gravity water where possible in order to ensure that people have access to water. It is not enough for National Water and Sewerage Corporation to postpone the collection of water bills in urban areas. At the end of the pandemic, vulnerable and poor families will be overburdened by arrears. Government should ensure that during the COVID-19 period and beyond, all the poor do not pay for water and services.

This is the time to reverse the privatization policy that is antithetical to realization to the rights to health and water. There is also urgent need to tackle gender related barriers to access health care, including domestic violence by vigorously enforcing the Domestic Violence Act, 2010, when complaints are reported to the police and other law enforcement agencies.

6.3. Mobilize and Deploy Resources

Government must harness and deploy the maximum of its resources in order to ensure the discharge of its core obligations above. Resources include financial, natural, human (such as medical professionals, community health workers and volunteers), technological such as Internet and equipment for testing and screening, and information resources. It is gratifying that H.E. President Museveni has taken a lead in mobilizing the private sector for donations towards the COVID-19 response and the sector is responding well.

Government should take measures to protect health care workers from exposure to and infection with the corona virus since they are an essential part of the state's essential resources to combat the pandemic. It should also ensure that all necessary, genuine and unfiltered information is available to the public. COVID-19 response is also a wakeup call to government to in future set up buffer stocks and food reserves to handle natural disasters like COVID-19.

6.4. Ensure Participation in COVID-19 Response

The human right to participation, which is a cardinal component of the right to health, is recognized in various international, regional and national human rights instruments (article 21, UDHR). The Constitution also provides that '[t]he state shall be based on democratic principles which empower and encourage the active participation of all citizens at all levels in their own governance' (objective II(I)) and all citizens have 'the right to participate in the affairs of government' (article 38). The 1978 Declaration of Alma-Ata on primary health care (PHC) (WHO, 1978) encourages an integrated

approach to health care and prevention and stresses people's 'right and duty to participate individually and collectively in the planning and implementation of their health care' (paras III, VI (5)). It enjoins governments to facilitate the participation of communities and individuals in the planning, organization, operation and control of primary health care, including educating communities on their right to participation (paras III, VI (5). Building on the PHC concept, the CESCR has noted that individuals and groups are entitled to participate in all government decisions affecting their health, including agenda setting and decision making (para. 54, General Comment 14).

Thus, government should ensure that the people and CSOs are actively involved in any response to the pandemic. Government should for example invite CSOs engaged in health and food issues to a round table to discuss strategies that may be employed to reach vulnerable and marginalized individuals and groups in society during this COVID-19 crisis.

6.5. Ensure Free Flow of Information

The right to participation is inextricably linked to other human rights such as access to education and information. When individuals and communities are knowledgeable about their health issues, including COVID-19 interventions, their active participation, may serve to hold government officials and service providers accountable for their actions. Thus, government should ensure that there is free flow of genuine and accurate information to all people about the nature of the corona virus, how it spreads and how it can be prevented. The government should caution people against relying on information on social media since most of it may be laden with conspiracy theories. They should instead largely rely on information originating from the Ministry of Health and WHO.

6.6. Take steps to combat all forms of stigma and discrimination

Government should, working with CSOs and volunteers, especially at the grassroots, sensitize communities not to stigmatize and discriminate against people suspected or believed to have COVID-19 or those who may have been discharged from quarantine or isolation and returned to the community. These people's dignity must be respected.

6.7. Ensure Periodic Review of the COVID-19 Response

Government should also ensure that there is a periodic review of COVID-19 response. The response should have a limited duration and be proportionate, necessary and evidence based. A person who is aggrieved by any of the public health measures should have a remedy, including applying to court or tribunal for review.

6.8. Observe Ethics

Government should also ensure privacy and confidentiality of data. According to the IHR (2005), all health information, including personal data must be kept confidential (article 45(1)). Personal data may only be released for the purpose of assessing and managing a public health risk (article 45(1)). Government should also ensure that all people, including travelers (article 23(3)), who are to be tested or screened for the corona virus have given their prior, free, informed consent. Informed consent is also critical in any vaccine or drug trials that may be conducted in the country with human beings as participants, otherwise, the findings are not acceptable.

Government should ensure that all ethical research protocols and procedures are complied with in accordance with international guidelines on research and the National Council of Science and Technology (NCST) Guidelines on Research involving Human subjects.

6.9. Support and Protect Health Workers.

Government should also support and protect health care workers who are at the frontline of the war against the pandemic. Following the COVID-19 response, people stay at home but health workers, including doctors and nurses and other staff, must go to hospitals and health centres thereby putting them at risk of the corona virus.

Thus, government should, in order to minimize occupational safety and health risks, provide health workers with protective gear, including masks, gloves, gowns, hand sanitizers, soap, water, and cleaning supplies in sufficient quantity. As the Lancet has observed, '[i]t is vital that governments see health workers not simply as pawns to be deployed but, as human individuals' (The Lancet, 2020) with family, interests, worries, anxieties and concerns. Thus, health care workers and their families need to be supported with essentials such as food and water, medical care, transport, rest and family support. They should also be promptly paid their risk and other allowances. The community should support health workers and avoid stigmatizing them for handling or being in contact with persons infected with the corona virus.

6.10. Do not 'Politicize' the Fight against the Pandemic

Government should not 'politicize' the fight against the pandemic. Recent threats by President Museveni to arrest opposition politicians who wanted to distribute food and other provisions to vulnerable groups and ostensibly have them charged with 'attempted murder' may be counterproductive. Government cannot fight the pandemic alone. We are all affected.

Government should encourage individuals, civil society organizations, faith-based institutions, political parties and private persons, including business people, to support and supplement its efforts in fighting the pandemic. It is good that at the press conference held on 8 April 2020, the President recognized, though tongue in cheek, a donation from People Power pressure group led by Hon. Kyagulanyi alias Bobi Wine.

6.11. Actively Involve the Private Sector in the Fight

There is need to actively involve CSOs in the war against the pandemic. CSOs should be provided with special permits and vehicle stickers to enable them reach the poor, vulnerable and marginalized groups they serve. Some of the leading CSOs should be allowed to open and work subject to minimum standards agreed with the Ministry of Health. It is a fact that CSOs play a fundamental role in the promotion of the right to health in the country and government should not neglect this critical resource. What is required is a 'whole-of-government' and 'whole-of society' coordinated COVID-19 response.

6.12. Hold all Agencies Involved in the COVID-19 Response Accountable

All agencies involved in the COVID-19 response must not violate human rights of all people including travelers. The IHR (2005) oblige states parties to treat all travelers with respect for their dignity, human rights and freedoms (article 32). Any violations must be reported and the errant officers involved must be held accountable.

6.13 State of Emergency Should be the Last Resort.

The constitutionality of the COVID-19 response has been questioned by some commentators who have recommended a declaration of a state of emergency (Busingye-Kabumba, 2020). A state of emergency is allowed by the Constitution (articles 46 and 110)) and may be imposed in exceptional circumstances such as a public health emergency where there is a threat to the life of a nation through high mortalities and morbidities (Human Rights Committee, General Comment No. 19)). It must also be limited to the extent strictly required by the emergency or situation (Human Rights Committee, General Comment No. 19).

The public health measures, including a curfew, are justifiable and acceptable under article 43 of the Constitution for purposes of tackling a public health challenge – the COVID-19 (Twinomugisha, 2020). A declaration of a state of emergency should be the last resort and must meet acceptable international standards as well as all the criteria under article 110 of the Constitution.

7. What Role for CSOs?

7.1 Lobby and Engage the Authorities

CSOs should lobby and engage government to appreciate their role and place them in the category that provides essential services. When this is done, some, if not all their staff should be issued with special permits and vehicle stickers to enable them reach the vulnerable individuals and groups they serve.

7.2. Be Proactive and Innovative

Without waiting for government permission to operate during this period, CSOs can use resources such as the media (print and electronic, including social media, radios and TV) to pass on material information, for example on sexual and reproductive health. CSOs may also use boda bodas to deliver critical health care goods and services such as condoms, contraceptives, maternal health care supplies ('mama kit'), ARVs, morphine and other pain killers for cancer and terminally ill patients.

However, CSOs should inform and consult the Ministry of Health on whatever activities they may intend to carry out in order to avoid confusion and an uncoordinated response. Companies like JUMIA can be engaged to collect and deliver critical health care products to clients. CSOs should, where possible, provide psycho-social support to some of the clients, who may be dealing with anxiety and depression due to the COVID-19 crisis.

CSOs such as Centre for Health, Human Rights and Development (CEHURD) and Human Rights Awareness and Promotion Forum (HRAPF), should, working with grassroots organizations and contacts, be on the lookout for emergency cases such as unsafe abortion, which may require post abortion care. CSOs should also follow up whether the WHO guidelines on quarantine and isolation are being met by the those involved. CSOs should also document violations of health-related rights by the state and non-state actors so that the perpetrators may be held accountable during and after the COVID-19 pandemic.

All this can be done through the Internet or phone using sms, WhatsApp and other electronic means of communication. After the pandemic, CSOs should conduct empirical research in order to obtain selected people's (especially patients') experiences and concerns during the COVID-19 response. The results may inform advocacy efforts of CSOs.

7.3 Hold Virtual Meetings

CSOs should hold virtual meetings among themselves and crucial partners about challenges and possible opportunities associated with the COVID-19. For example, the Coalition on the Reduction of Maternal Mortality and Morbidity should mobilize CSOs engaged in maternal health questions; and UGANET could organize those engaged in HIV/AIDS related issues at the macro and micro levels. This is critical if CSOs are to engage authorities with one voice and not lose their legitimacy during this trying period.

8. Conclusion.

There is no doubt whatsoever, that human rights generally and the right to health in particular, have been or will be adversely affected by the COVID-19 response. Any deprivation of enjoyment of human rights is for public interest – the protection of public health. However, government should ensure that the public health measures in question are implemented without unduly burdening human rights. Human rights, including the right to health, should be at the centre of any public health measures, strategies, interventions and practices. Human rights should guide all efforts to tackle the pandemic, including ensuring participation by all affected communities in all response measures.

There should be no derogation from health rights that accrue from the core obligations of the government in the context of the right to health. The government should implement the strategies advanced above in order to mitigate the adverse impacts of the COVID-19 response especially on the poor, marginalized and vulnerable groups of society. CSOs cannot simply

twiddle their thumbs: they must be proactive and innovative and devise strategies to help these groups in the face of the COVID-19 response.

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