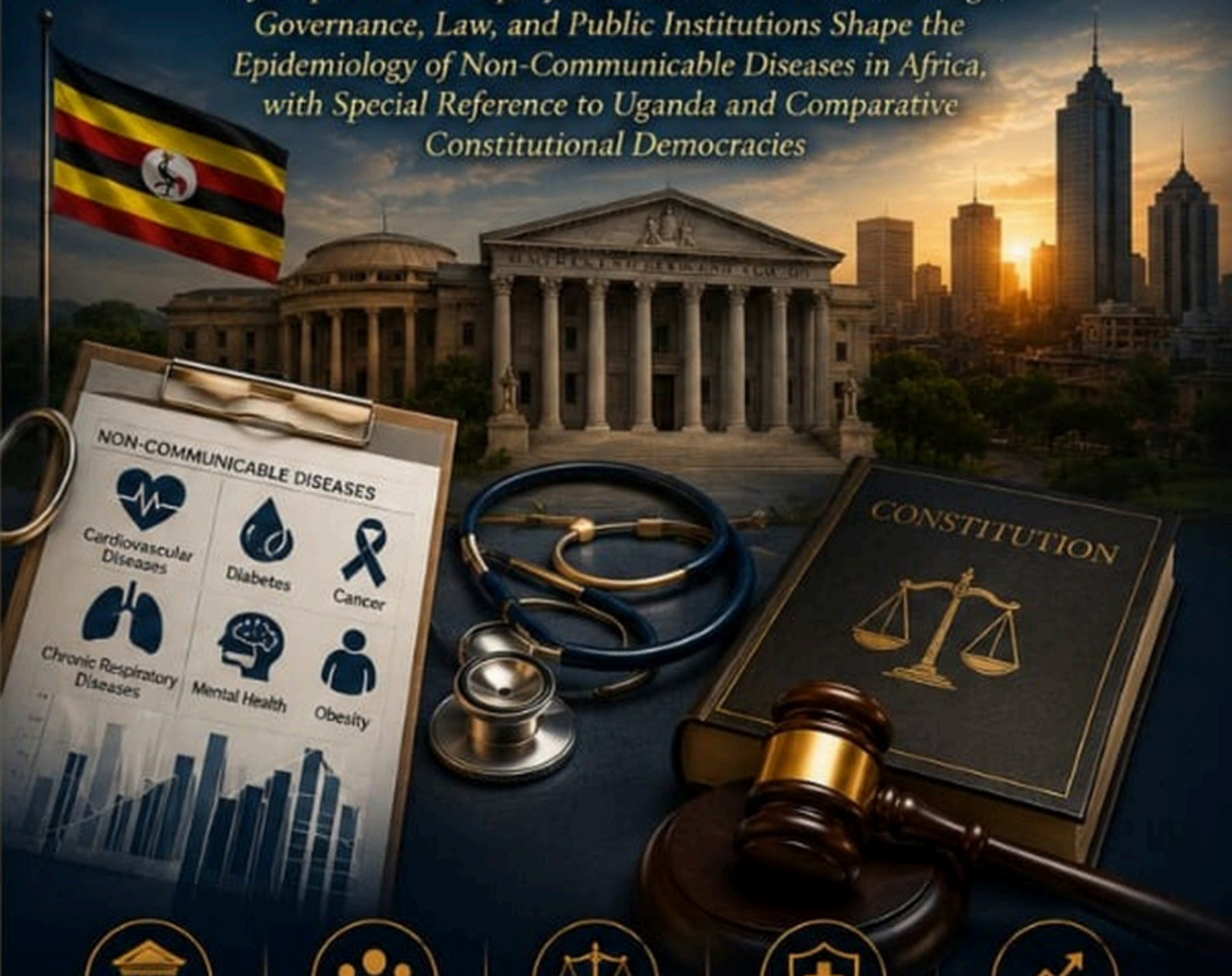
CONSTITUTIONAL EPIDEMIOLOGY

HEALTH CONSTITUTIONALISM, AND THE JURISPRUDENCE OF PREVENTION

A Jurisprudential Inquiry into How Constitutional Design, Governance, Law, and Public Institutions Shape the Epidemiology of Non-Communicable Diseases in Africa, with Special Reference to Uganda and Comparative Constitutional Democracies



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ABSTRACT

Africa's escalating burden of non-communicable diseases — cardiovascular disease, diabetes, cancer, chronic respiratory illness, obesity, kidney disease, stroke, and mental illness — is conventionally analysed as a biomedical and behavioural phenomenon. This monograph departs from that orthodoxy. It advances Constitutional Epidemiology as an original jurisprudential theory holding that disease patterns are substantially produced by constitutional design, legal architecture, governance choices, institutional accountability, and the distribution of public power. Constitutions, on this account, are not merely political charters; they are epidemiological instruments, capable of preventing disease or, through silence and structural failure, of producing it.

The work develops two companion doctrines. Health Constitutionalism argues that twenty-first-century constitutions must evolve beyond the protection of civil and political liberties to impose positive, enforceable obligations on the state to prevent disease, regulate harmful industries, and create the structural conditions for healthy life. The Jurisprudence of Prevention asks whether courts can and should develop preventive constitutional doctrines — structural injunctions, anticipatory remedies, and regulatory duties — capable of compelling government action before preventable illness and death occur, rather than merely compensating harm after the fact.

Uganda is examined as the principal case study, its constitutional text, National Objectives and Directive Principles of State Policy, health legislation, and institutional practice analysed against the comparative experience of South Africa, Kenya, India, Colombia, Brazil, the United States, and the United Kingdom, and against the interpretive architecture of international and African regional human rights law. The monograph closes by proposing a transformation from reactive to preventive constitutional orders, in which the protection of population health is recognised as a central and justiciable constitutional responsibility.

Keywords: *Constitutional Epidemiology; Health Constitutionalism; Jurisprudence of Prevention; non-communicable diseases; preventive health law; Uganda; comparative constitutional law; commercial determinants of health.*

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PREFACE

This monograph is written from a conviction formed over years of constitutional practice and scholarship in Uganda: that the gravest threats to African lives are no longer confined to the courtroom's traditional subject matter of elections, land, and civil liberty, but increasingly reside in the slow, undramatic architecture of governance itself — in tax codes that fail to price harm, in food systems left unregulated, in health budgets structured without enforceable priority, and in constitutional silences that courts have not yet learned to hear.[1]

The non-communicable disease burden confronting Uganda and the wider African continent is frequently narrated as a medical emergency, to be solved by clinicians, epidemiologists, and health financiers. This book does not dispute the centrality of that expertise. It argues, instead, that the expertise is necessary but insufficient — that disease patterns are also, and irreducibly, constitutional phenomena, produced or prevented by the design of public power.

The theory advanced here — Constitutional Epidemiology — together with its companion doctrines of Health Constitutionalism and the Jurisprudence of Prevention, is offered not as a finished orthodoxy but as an opening contribution, intended to invite critique, refinement, and application by scholars, judges, legislators, and health policymakers across Africa and beyond.

Isaac Christopher Lubogo
Kampala

[1]The author acknowledges the extensive public health literature on social and commercial determinants of health that informs this constitutional reading, discussed fully in Chapter 1.

GENERAL INTRODUCTION

Africa stands at an epidemiological inflection point. For much of the twentieth century, the continent's health burden was dominated by infectious disease — malaria, tuberculosis, HIV/AIDS, and a succession of epidemic and pandemic threats that mobilised extraordinary international investment, emergency legal instruments, and coordinated multilateral response. Non-communicable diseases, by contrast, have advanced quietly, absorbing an ever-larger share of morbidity and mortality while remaining constitutionally and institutionally under-addressed.[2]

This monograph's foundational proposition is that the growth of this burden cannot be explained by biology and behaviour alone. It is also a story of constitutional design — of what constitutions require, permit, or fail to require of the institutions responsible for taxation, food regulation, environmental protection, urban planning, education, and healthcare financing. Where constitutional text is silent, where directive principles are unenforceable, where regulatory agencies lack independence, and where judicial doctrine has not yet developed tools of prevention, disease is permitted to flourish not despite the constitutional order but, in a meaningful sense, through it.

The book is structured in six parts. Part I lays the theoretical foundations, introducing Constitutional Epidemiology, Health Constitutionalism, and the Jurisprudence of Prevention as three interlocking doctrines. Part II situates these doctrines within international, African regional, and comparative constitutional authority. Part III undertakes a sustained case study of Uganda, examining constitutional text, statute, policy, and institutional practice. Part IV addresses the political economy of disease — the commercial determinants of health and the emerging discipline of preventive health law. Part V extends the theory to frontier concerns: artificial intelligence, climate change, traditional medicine, and national security. Part VI offers synthesis and constitutional, legislative, and judicial recommendations.[3]

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[2]World Health Organization, Noncommunicable Diseases Progress Monitor 2022 (WHO, Geneva 2022), documenting the rising share of NCD mortality in low- and middle-income countries, including sub-Saharan Africa.

[3]The Part-by-Part structure follows the thematic architecture originally proposed in the book concept,

This first published instalment presents Part I in full. Parts II through VI, together with the bibliography and subject index, are being finalised and will follow in subsequent instalments, consistent with the scale and rigour the subject demands.

refined here into a sequential jurisprudential argument.

PART I — FOUNDATIONS

CHAPTER 1
THE CONSTITUTIONAL EPIDEMIOLOGY THEORY

1.1 The Foundational Proposition

The central claim of this chapter is deceptively simple to state and considerably more demanding to establish: disease patterns within a political community are not determined solely by biology, genetics, or individual behaviour, but are substantially shaped by constitutional design, legal architecture, governance choices, institutional accountability, and the distribution of public power. Constitutions, on this account, are not merely political charters allocating offices and enumerating rights; they are epidemiological instruments, structurally capable of preventing disease or, through omission and design failure, of producing it.[4]

The proposition is not that constitutions cause disease in any mechanical or deterministic sense. It is, more precisely, that constitutional choices — about the allocation of legislative competence over health and environment, about the justiciability of socio-economic rights, about the independence of regulatory agencies, about fiscal architecture and revenue allocation, and about the accountability mechanisms available to citizens harmed by regulatory failure — structure the probability distribution of disease across a population. A constitution that entrenches strong, independent food and drug regulation, that enables litigation against harmful commercial conduct, and that requires transparent budgetary allocation to preventive health will, other things being equal, produce a different epidemiological profile than one that is silent on these matters.

This is a claim about structural causation operating at a remove from clinical causation. No constitution directly causes a myocardial infarction or a diagnosis of type 2 diabetes in any single patient. But constitutions shape the background conditions — the price and availability of tobacco and sugar-sweetened beverages, the ambient air quality of cities, the built environment's capacity to support physical activity, the affordability of insulin and chemotherapy, the presence or absence of

[4]Compare Lawrence O. Gostin and Lindsay F. Wiley, Public Health Law: Power, Duty, Restraint (3rd edn, University of California Press 2016), on law as a determinant of population health outcomes, from which the present theory draws while extending the analysis to constitutional-level design choices.

enforceable rights to challenge regulatory neglect — within which millions of individual clinical outcomes accumulate into population-level disease burden.[5]

1.2 Constitutions as Epidemiological Instruments

To describe a constitution as an epidemiological instrument is to make three interlocking assertions. First, that constitutional text and structure allocate the regulatory and fiscal authority upon which disease prevention depends. Second, that constitutional interpretation — the manner in which courts read directive principles, socio-economic rights, and the right to life — determines whether that authority translates into enforceable obligation or remains aspirational. Third, that constitutional culture — the political and institutional habits that grow up around a constitutional text — determines whether prevention is treated as a governance priority or is perennially deferred in favour of more visible, more immediately electorally rewarding, forms of state action.

> *A constitution silent on prevention is not a neutral constitution. It is a constitution that has, by omission, left the field open to those commercial and political interests whose incentives run counter to population health.*

This formulation deliberately echoes, while extending, the well-established public health law literature on legal epidemiology — the scientific study of the relationship between law and health outcomes.[6]

Legal epidemiology has traditionally focused on statutory and regulatory interventions — smoke-free laws, seatbelt mandates, sugar taxes — and their measurable effect on health outcomes. Constitutional Epidemiology asks a prior question: what constitutional conditions make such statutory interventions possible, durable, and enforceable in the first place? A sugar tax enacted by ordinary legislation can be repealed by the next parliamentary majority responsive to industry lobbying. A constitutional duty to regulate harmful commercial conduct, interpreted purposively by an independent judiciary, is considerably more resilient.

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[5]On the distinction between individual and structural causation in public health, see Nancy Krieger, 'Theories for Social Epidemiology in the 21st Century: An Ecosocial Perspective' (2001) 30 International Journal of Epidemiology 668.

[6]Scott Burris, Micah Berman, Matthew Penn and Tara Ramanathan Holiday (eds), The Legal Epidemiology of Chronic Disease Prevention (Public Health Law Research, Temple University, 2016).

1.2.1 The Three Levels of Constitutional Influence

Constitutional influence on epidemiological outcomes operates at three analytically distinct levels. The first is allocative: constitutions determine which level of government, and which institution, holds authority over taxation, food regulation, environmental governance, and healthcare financing, and thereby determine where the political accountability for disease prevention (or its absence) is located.[7]

The second is interpretive: constitutional courts, through their reading of rights to life, dignity, equality, and a healthy environment, either open or close the door to health-related litigation, and thereby determine whether citizens and civil society organisations possess an enforceable mechanism to compel preventive state action.

The third is cultural: constitutions generate, over time, a political culture of either reactive or anticipatory governance. Where constitutional discourse habitually frames government's obligations in terms of remedy after harm — compensation, emergency response, curative healthcare financing — rather than in terms of anticipatory duty, the entire apparatus of the state, from budget officers to regulatory inspectors, internalises a reactive posture that structurally under-invests in prevention.

1.3 The Ten Propositions of Constitutional Epidemiology

The theory rests on ten interlocking propositions, each of which is developed and defended, with supporting comparative and Ugandan authority, in the chapters that follow. They are stated here in summary form as the theory's organising architecture.

Proposition One: Constitutional structures determine health financing priorities.

The constitutional allocation of budgetary authority, and the presence or absence of entrenched minimum spending obligations, structurally determines whether preventive health programmes receive priority over curative and emergency expenditure, which tends to dominate health budgets in the absence of a

[7] On multi-level governance and health federalism generally, see Scott L. Greer, 'The Territorial Politics of Health Policy' in Scott L. Greer (ed), Territory, Democracy and Justice (Palgrave Macmillan 2006).

constitutional counterweight.[8]

Proposition Two: Constitutional allocation of powers influences health outcomes.

Whether health and environmental regulation is centralised, devolved, or shared between national and local government materially affects both the responsiveness and the capture-resistance of regulatory action, a proposition examined in detail in the Ugandan case study in Part III.

Proposition Three: Public accountability mechanisms affect disease prevention.

The availability of public interest litigation, freedom of information, parliamentary oversight, and independent audit determines whether regulatory failure in the health sector is exposed, contested, and corrected, or is permitted to persist unchallenged.

Proposition Four: Environmental governance shapes exposure to health risks.

Constitutional protection of the environment — where it exists as an enforceable right rather than an aspiration — directly shapes population exposure to air pollution, water contamination, and industrial hazard, each independently implicated in cardiovascular, respiratory, and renal disease.[9]

Proposition Five: Food regulation influences obesity, diabetes, and cardiovascular disease.

The constitutional and statutory capacity of the state to regulate food composition, labelling, and marketing — particularly to children — is a primary structural determinant of dietary disease risk across a population.

Proposition Six: Tax policy affects tobacco, alcohol, sugary beverages, and ultra-processed food consumption.

Fiscal constitutional design, including the ease or difficulty of enacting and sustaining targeted excise taxation, is among the most extensively evidenced levers

[8]See generally Katharina Pistor, 'A Legal Theory of Finance' (2013) 41 Journal of Comparative Economics 315, on the structural relationship between legal architecture and resource allocation, applied here to the health sector.

[9]World Health Organization, Ambient Air Pollution: A Global Assessment of Exposure and Burden of Disease (WHO, Geneva 2016).

of non-communicable disease prevention available to any government.[10]

Proposition Seven: Urban planning determines physical activity, pollution exposure, and access to healthy environments.

Constitutional and local government competence over land use, zoning, and infrastructure investment structurally shapes the built environment within which physical activity is either facilitated or foreclosed.

Proposition Eight: Education systems shape public health literacy.

The constitutional right to education, and its curricular content, determines the population's baseline capacity to understand and act upon health information, a foundational condition for the effectiveness of any preventive health intervention.

Proposition Nine: Judicial protection of rights influences access to medicines and treatment.

Comparative experience, examined at length in Part II, demonstrates that judicial willingness to enforce socio-economic rights materially affects the availability of essential medicines and treatment, particularly for the poorest and most marginalised populations.[11]

Proposition Ten: Anti-corruption frameworks determine the effectiveness of health systems.

Constitutional and institutional anti-corruption architecture determines whether health financing reaches its intended preventive and curative purposes, or is diverted through procurement fraud, ghost programming, and administrative leakage — a persistent constraint on health system performance across the region.[12]

Taken together, these ten propositions support the chapter's summary conclusion: disease is, in significant and previously under-theorised part, a constitutional product.

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[10]World Health Organization, WHO Report on the Global Tobacco Epidemic 2021: Addressing New and Emerging Products (WHO, Geneva 2021), documenting the evidenced effect of tobacco taxation on consumption.

[11]See Minister of Health v Treatment Action Campaign (No 2) 2002 (5) SA 721 (CC), discussed fully in Chapter 6.

[12]Transparency International, Global Corruption Report: Corruption in the Health Sector (Transparency International 2006), remaining broadly instructive on the structural vulnerabilities of health procurement.

1.4 Distinguishing Constitutional Epidemiology from Existing Fields

Constitutional Epidemiology is not a claim to originality without genealogy. It builds deliberately upon, while remaining distinct from, four established bodies of scholarship: public health law, the social determinants of health literature, legal epidemiology, and health justice scholarship.

Public health law examines the statutory and regulatory powers of the state to protect population health, typically without sustained attention to constitutional structure as an independent variable.[13]

The social determinants of health literature, associated foundationally with the World Health Organization's Commission on Social Determinants of Health, examines the social gradient of health but generally treats governance and political structure as background context rather than as the direct object of legal-doctrinal analysis.[14]

Legal epidemiology, as noted above, studies the health effects of specific laws empirically but does not typically ask constitutional-theoretical questions about the entrenchment, durability, and justiciability of those laws. Health justice scholarship, most closely allied with the present project, examines the intersection of law, health, and structural inequality, but has not to date been systematised into a discrete constitutional theory applied comparatively to African jurisdictions with Uganda as principal case study.[15]

Constitutional Epidemiology's distinct contribution is threefold: it treats constitutional design itself, rather than ordinary legislation, as the primary object of epidemiological analysis; it develops two companion doctrines — Health Constitutionalism and the Jurisprudence of Prevention — capable of guiding judicial and legislative practice; and it grounds the theory in sustained comparative and African-regional authority, with Uganda developed as a full case study rather than a passing illustration.

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[13]Lawrence O. Gostin, Public Health Law and Ethics: A Reader (2nd edn, University of California Press 2010).

[14]WHO Commission on Social Determinants of Health, Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health (WHO, Geneva 2008).

[15]Compare Elizabeth Tobin Tyler and others (eds), Poverty, Health and Law: Readings and Cases for Medical-Legal Partnership (Carolina Academic Press 2011).

1.5 Methodology and Sources of Authority

The methodology adopted throughout this monograph is doctrinal and comparative, supplemented by public health evidence deployed for its explanatory rather than its dispositive legal weight. Four categories of authority are used consistently. First, binding and persuasive constitutional and statutory text, principally the Constitution of the Republic of Uganda, 1995 (as amended), read alongside comparative constitutional instruments. Second, international and African regional human rights instruments and their authoritative interpretive commentary, particularly the International Covenant on Economic, Social and Cultural Rights and General Comment No. 14 of the Committee on Economic, Social and Cultural Rights.[16]

Third, comparative constitutional jurisprudence, principally from South Africa, Kenya, India, Colombia, Brazil, the United States, and the United Kingdom, selected for their doctrinal diversity in the treatment of socio-economic and environmental rights. Fourth, public health and epidemiological evidence, drawn primarily from World Health Organization technical reports and peer-reviewed epidemiological literature, deployed throughout not to establish legal propositions but to establish the factual predicate — the scale and structure of the non-communicable disease burden — against which the constitutional argument is tested.

1.6 The Epidemiological Transition and Its Constitutional Neglect

The demographic and epidemiological transition literature describes a well-documented historical pattern in which populations move, as mortality and fertility decline, from a disease burden dominated by infectious disease, malnutrition, and maternal mortality toward one dominated by chronic, non-communicable disease.[17]

Sub-Saharan Africa, including Uganda, is now understood to be undergoing this transition considerably faster than the historical experience of Europe and North

[16]International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3, art 12; UN Committee on Economic, Social and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) UN Doc E/C.12/2000/4 (11 August 2000).

[17]Abdel R. Omran, 'The Epidemiologic Transition: A Theory of the Epidemiology of Population Change' (1971) 49 Milbank Memorial Fund Quarterly 509, the foundational statement of epidemiological transition theory.

America, a phenomenon epidemiologists term the 'compressed' or 'protracted-polarised' transition, in which infectious and non-communicable disease burdens coexist and compound rather than succeeding one another in orderly historical sequence.[18]

This chapter argues that constitutional and legal systems across the region, including Uganda's, were substantially designed — in their public health provisions, statutory drafting, and institutional architecture — during and for the earlier, infectious-disease-dominated phase of this transition, and have not undergone a corresponding structural modernisation to meet the governance demands of the non-communicable disease phase now underway. This mismatch between epidemiological reality and constitutional-institutional design is, this chapter contends, itself among the clearest empirical illustrations of Constitutional Epidemiology's foundational proposition.

1.7 Constitutional Silence as Structural Choice

A recurring objection to Constitutional Epidemiology, addressed here and revisited in Chapter 2's treatment of doctrinal objections, is that constitutional silence on a subject cannot properly be characterised as a constitutional 'choice' at all, but merely as an absence of textual engagement, carrying no independent normative weight.[19]

This chapter responds that silence operates differently depending on institutional context. Where a constitutional text is silent on a matter that could readily have been addressed — as with the considered, article-by-article drafting process that produced Uganda's 1995 Constitution following the Odoki Commission's extensive public consultation — silence is properly read, this chapter argues, as reflecting the drafters' operative assumptions about the state's proper role, assumptions themselves shaped by the infectious-disease-dominated

[18]Milton I. Roemer, 'Rural Health Care Delivery, and Health Policy' and later synthesis by Salim Yusuf and others, 'Global Burden of Cardiovascular Diseases: Part I' (2001) 104 Circulation 2746, documenting the compressed transition pattern in developing regions.

[19]Compare the general jurisprudential debate on the interpretive significance of legislative and constitutional silence in Cass R. Sunstein, 'Interpreting Statutes in the Regulatory State' (1989) 103 Harvard Law Review 405, addressing an analogous methodological question in the statutory context.

epidemiological reality of the drafting period.[20]

The doctrinal consequence, developed fully in Chapter 2, is that constitutional silence should not be read as foreclosing the composite health duty this monograph advances, but rather as historically contingent and open to reinterpretation as the epidemiological and evidentiary landscape evolves — a standard interpretive move well recognised in comparative constitutional theory under the doctrine of the 'living constitution' or evolutive interpretation.[21]

1.8 Quantifying the Burden: Uganda's Epidemiological Profile

Before developing the theory's normative content further in Chapters 2 and 3, it is necessary to establish with some precision the scale of the epidemiological phenomenon this monograph addresses. WHO STEPS survey data for Uganda indicates a substantial and rising prevalence of the principal behavioural NCD risk factors — raised blood pressure, raised blood glucose, harmful alcohol use, tobacco use, and insufficient physical activity — across both urban and, increasingly, rural populations.[22]

The Institute for Health Metrics and Evaluation's Global Burden of Disease study estimates that non-communicable diseases now account for a substantial and growing proportion of Uganda's total disability-adjusted life years, with cardiovascular disease, and increasingly cancer, rising most rapidly among the specific disease categories tracked.[23]

This empirical picture, elaborated further with district-level and demographic disaggregation in Chapter 9's institutional analysis and Chapter 12's rights-based treatment, supplies the factual predicate against which this monograph's central

[20]Uganda Constitutional Commission (the Odoki Commission), Report of the Uganda Constitutional Commission: Analysis and Recommendations (Uganda Printing and Publishing Corporation, Entebbe 1993), documenting the extensive consultative process preceding the 1995 Constitution's health-related provisions.

[21]Compare the evolutive interpretation doctrine applied by the European Court of Human Rights, eg Tyrer v United Kingdom App No 5856/72 (ECtHR, 25 April 1978) para 31, describing the Convention as 'a living instrument which... must be interpreted in the light of present-day conditions'.

[22]Ministry of Health, Uganda, WHO STEPS Survey Uganda 2014 Report (Ministry of Health, Kampala 2014), and subsequent updates, documenting rising NCD risk factor prevalence across the surveyed period.

[23]Institute for Health Metrics and Evaluation, Global Burden of Disease Study 2021: Uganda Country Profile (IHME, Seattle 2022).

constitutional argument — that this burden is not simply a clinical phenomenon but a product of governance choice — must be tested and, this book argues, is substantially borne out.

1.9 A Worked Illustration: Insulin Availability as a Constitutional Epidemiology Case Study

To move from abstraction to application, this chapter closes Part I's opening chapter with a worked illustration that will recur throughout this monograph: the persistent, well-documented unavailability of insulin at Ugandan public health facilities, a phenomenon this chapter uses to demonstrate each of the ten propositions developed in section 1.3 operating simultaneously within a single, concrete governance failure.[24]

Insulin's constitutional significance lies precisely in its epidemiological ordinariness: type 1 diabetes is not a rare or exotic condition but a well-understood, well-treatable disease for which insulin is, on the WHO's own Essential Medicines List, indisputably essential. Its unavailability is therefore not attributable to scientific uncertainty, diagnostic difficulty, or contested medical opinion — the standard justifications for regulatory caution — but to the chain of governance failures traced in this book: inadequate budgetary priority (Proposition One), fragmented procurement authority between the National Medical Stores and the Ministry of Finance (Proposition Two), weak parliamentary and civil society tracking of stock-out data (Proposition Three), and the absence, prior to this monograph's Chapter 3 proposal, of any accessible judicial remedy for the individuals and families affected.[25]

This chapter's illustration is deliberately revisited at the close of Chapter 4 (in the minimum core context), Chapter 8 (in the essential medicines statutory context), and Chapter 17 (in the concluding synthesis), precisely to demonstrate that Constitutional Epidemiology's ten propositions are not free-standing abstractions but describe, cumulatively, the anatomy of a single recurring, remediable governance

[24]International Diabetes Federation, IDF Diabetes Atlas (10th edn, IDF, Brussels 2021), documenting insulin access gaps across sub-Saharan Africa including Uganda.

[25]WHO, WHO Model List of Essential Medicines, 22nd List (WHO, Geneva 2021), listing insulin (human and analogue) as an essential medicine.

failure — one this monograph argues is emblematic of the wider non-communicable disease governance challenge across the African continent.

The chapters that follow proceed from this foundation to develop, in turn, the doctrine of Health Constitutionalism (Chapter 2) and the Jurisprudence of Prevention (Chapter 3), before Part II situates both doctrines within the wider architecture of international, regional, and comparative constitutional authority.

CHAPTER 2
HEALTH CONSTITUTIONALISM

2.1 From Negative Liberty to Positive Obligation

The classical liberal constitutional tradition, inherited across much of Anglophone Africa through colonial constitutional transplantation, conceives of constitutional rights principally as negative liberties: protections against state interference with life, liberty, property, and expression.[26]

Health Constitutionalism argues that this negative paradigm is structurally inadequate to the epidemiological challenge of non-communicable disease. Non-communicable diseases are not, in the main, caused by discrete acts of state interference against which a negative right offers protection. They are caused by the cumulative, population-level exposure to commercially produced risk — tobacco, alcohol, ultra-processed food, air pollution — against which only a positive, regulatory state can offer meaningful protection. A constitution that protects citizens only from state action, and not from the foreseeable consequences of state inaction, is systematically incapable of addressing the modern epidemiological reality.

Health Constitutionalism therefore proposes that twenty-first-century constitutions must evolve to impose positive, enforceable obligations on the state to prevent disease, regulate health risks, and create environments that promote healthy lives. This is not a novel move in constitutional theory generally — the recognition of positive socio-economic obligations is well established in comparative and international law — but its systematic application to the specific problem of non-communicable disease prevention has not, prior to this work, been undertaken with comparable rigour.[27]

2.2 The Six Constitutional Duties

[26] On the negative-liberty paradigm and its colonial transmission to African constitutions, see H.W.O. Okoth-Ogendo, 'Constitutions without Constitutionalism: Reflections on an African Political Paradox' in Douglas Greenberg and others (eds), Constitutionalism and Democracy: Transitions in the Contemporary World (Oxford University Press 1993).

[27] On the general theory of positive constitutional obligation, see Cass R. Sunstein, 'Against Positive Rights' (1993) 2 East European Constitutional Review 35, for the sceptical position, and David Bilchitz, Poverty and Fundamental Rights: The Justification and Enforcement of Socio-Economic Rights (Oxford University Press 2007), for the affirmative position adopted and extended in this chapter.

Health Constitutionalism specifies six constitutional duties that, taken together, constitute the doctrine's operative content. Each duty is stated here in general form; each is elaborated with supporting comparative authority in Part II and applied to the Ugandan constitutional text in Part III.

2.2.1 The Duty to Prevent Disease

The state bears a constitutional duty to take reasonable, evidence-based measures to prevent foreseeable, population-scale disease, analogous to — and, this book argues, a natural extension of — the well-established duty to protect life from foreseeable third-party harm.[28]

2.2.2 The Duty to Regulate Harmful Industries

Where commercial conduct is demonstrably and foreseeably harmful to population health — as with tobacco, and increasingly with sugar-sweetened beverages and ultra-processed food — the state bears a constitutional duty to regulate that conduct proportionately, a duty that cannot be discharged by silence or by regulatory capture.

2.2.3 The Duty to Ensure Equitable Access to Healthcare

The state bears a duty to structure healthcare financing and delivery so that access to prevention, diagnosis, and treatment is not determined by wealth, geography, or political favour, a duty most fully elaborated in comparative jurisprudence from South Africa and India, examined in Chapter 6.

2.2.4 The Duty to Protect Vulnerable Populations

Children, persons with disabilities, the elderly, and the rural poor bear disproportionate exposure to preventable non-communicable disease risk, and the state's constitutional duty of protection is correspondingly heightened with respect to these populations.[29]

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[28]Compare the positive-obligation jurisprudence under art 2 of the European Convention on Human Rights, notably Osman v United Kingdom App No 23452/94 (ECtHR, 28 October 1998), extended by analogy in this monograph from the context of individual violent harm to the context of population-level commercially produced health risk.

[29]Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3, art 24, on the child's right to the highest attainable standard of health, informing the heightened duty articulated here.

2.2.5 The Duty to Guarantee Preventive Public Health Programmes

Beyond the regulation of harmful conduct, the state bears an affirmative duty to fund and deliver preventive public health programming — screening, vaccination, health education, and community-level intervention — proportionate to the scale of the identified disease burden.

2.2.6 The Duty to Uphold the Right to the Highest Attainable Standard of Health

The fifth and sixth duties converge in the internationally recognised right to the highest attainable standard of physical and mental health, which this chapter argues should be read, in African constitutional systems that lack an express standalone health right, as implicit within the rights to life, dignity, and equality, and within the National Objectives and Directive Principles of State Policy characteristic of the region's constitutional drafting tradition.[30]

2.3 Doctrinal Foundations in Comparative and International Law

Health Constitutionalism does not proceed in a doctrinal vacuum. It draws upon, and seeks to systematise, four established lines of comparative and international constitutional doctrine.

The first is the doctrine of positive state obligation under international human rights law, most fully developed under the European Convention on Human Rights and the jurisprudence of the UN human rights treaty bodies, which recognises that certain rights impose not only a duty of restraint but a duty of protective action.

The second is the South African doctrine of reasonableness review, developed in Grootboom and its progeny, which asks not whether a court can dictate the precise content of social policy, but whether the state's chosen measures are reasonable, given available resources, in progressively realising the right in question.[31]

The third is the Indian doctrine of the expansive right to life under Article 21 of

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[30]ICESCR (n above) art 12; General Comment No 14 (n above) paras 8-11, articulating the AAAQ framework — availability, accessibility, acceptability, and quality — adopted and applied throughout Part III of this monograph.

[31]Government of the Republic of South Africa v Grootboom 2001 (1) SA 46 (CC), discussed fully in Chapter 6.

the Constitution of India, through which the Supreme Court has read environmental protection, health, and dignified living conditions into the bare textual guarantee of life and personal liberty, a doctrinal move of direct relevance to Uganda's own Article 22.[32]

The fourth is the minimum core obligation doctrine associated with the UN Committee on Economic, Social and Cultural Rights, which holds that certain socio-economic entitlements possess an irreducible minimum content that the state must satisfy immediately, irrespective of resource constraints, with progressive realisation applying only above that minimum threshold.[33]

Health Constitutionalism synthesises these four doctrines into a single framework applicable to the specific problem of non-communicable disease: positive obligation establishes that the state must act; reasonableness review supplies the standard by which judicial deference to the manner of that action is calibrated; the expansive right-to-life doctrine supplies the textual hook in jurisdictions, including Uganda, lacking an express health right; and the minimum core doctrine identifies an irreducible floor — for example, availability of insulin, essential cancer medicines, and basic dialysis — below which resource constraints cannot be pleaded as a defence.

2.4 Objections and Responses

Three principal objections to Health Constitutionalism warrant direct engagement. The first is the separation-of-powers objection: that judicial enforcement of positive health duties illegitimately displaces the budgetary and policy discretion properly reserved to the elected branches.[34]

The response, developed at length in Chapter 3's treatment of the Jurisprudence of Prevention, is that reasonableness review — as opposed to the direct judicial specification of policy content — respects the separation of powers

[32]See eg Francis Coralie Mullin v Administrator, Union Territory of Delhi (1981) 1 SCC 608 (Supreme Court of India), discussed further in Chapter 6.

[33]UN Committee on Economic, Social and Cultural Rights, General Comment No. 3: The Nature of States Parties' Obligations UN Doc E/1991/23 (14 December 1990) para 10.

[34]For the classical statement of the separation-of-powers objection to socio-economic rights adjudication, see Jeff King, Judging Social Rights (Cambridge University Press 2012), engaging critically but ultimately, as this chapter argues, not decisively against justiciability.

precisely because it asks only whether the state has acted reasonably, leaving the choice of means to the political branches while insisting on the constitutional necessity of action itself.

The second objection is the resource-constraint objection: that African states, and Uganda in particular, lack the fiscal capacity to discharge extensive positive health duties. The response is that Health Constitutionalism does not require unlimited expenditure; it requires reasonable, progressively realised action calibrated to available resources, together with an irreducible minimum core — a standard considerably more modest than the objection suggests, and one substantially achievable through regulatory rather than purely expenditure-based intervention, such as taxation and marketing restriction, which are fiscally neutral or even revenue -positive.

The third objection is the vagueness objection: that a generalised duty to 'prevent disease' is too indeterminate to ground justiciable constitutional obligation. The response, developed through the six specified duties above and operationalised through the AAAQ framework of availability, accessibility, acceptability, and quality, is that the doctrine's content is considerably more determinate than the objection allows, and no more indeterminate than comparably general constitutional standards — reasonableness, proportionality, dignity — that courts across the comparative jurisdictions examined in this book apply as a matter of routine practice.

2.5 Health Constitutionalism and the Doctrine of Proportionality

Where the state does act to discharge its Health Constitutionalism duties — for instance, by restricting tobacco advertising or imposing a sugar tax — the resulting interference with commercial expression, property, or trade rights must itself satisfy constitutional scrutiny, typically through a proportionality analysis asking whether the measure pursues a legitimate objective, is rationally connected to that objective, is no more restrictive than necessary, and strikes a fair balance between the measure's benefits and its costs.[35]

This chapter argues that the substantial and consistent epidemiological

[35]On the structure of proportionality analysis in comparative constitutional law generally, see Aharon Barak, Proportionality: Constitutional Rights and Their Limitations (Cambridge University Press 2012).

evidence base underlying tobacco, alcohol, and increasingly sugar and ultra-processed food regulation supplies more than sufficient rational connection and necessity justification to satisfy proportionality review, a conclusion supported by the comparative jurisprudence upholding such measures against constitutional and trade-law challenge internationally, most prominently the WTO Appellate Body's decision in Australia — Plain Packaging, rejecting Honduras's, the Dominican Republic's, Cuba's, and Indonesia's challenges to Australia's tobacco plain packaging legislation.[36]

2.6 The Interaction Between Health Constitutionalism and Property and Trade Rights

A further objection to Health Constitutionalism, distinct from the three addressed in section 2.4, concerns its interaction with constitutionally protected property and trade rights, particularly the concern that extensive regulation of commercial products may constitute an uncompensated deprivation of property or an unjustifiable restriction on the freedom to conduct business.[37]

This chapter's response draws on the well-established comparative distinction between regulation of the terms on which a lawful business may be conducted — permissible under the state's general regulatory police power without compensation — and outright expropriation of property, a distinction consistently applied by comparative courts to uphold tobacco, alcohol, and food labelling and marketing regulation against property and trade rights challenge, including by the Constitutional Court of South Africa and the European Court of Justice.[38]

2.7 Health Constitutionalism in Federal and Decentralised Systems

This chapter's final section addresses a structural question of particular relevance to Uganda's decentralised system of government, examined further in

[36]Australia — Certain Measures Concerning Trademarks, Geographical Indications and Other Plain Packaging Requirements Applicable to Tobacco Products and Packaging (Australia — Plain Packaging), WT/DS435/AB/R, WT/DS441/AB/R (9 June 2020) (WTO Appellate Body).

[37]Constitution of the Republic of Uganda, 1995 (as amended), art 26, on protection from deprivation of property, and art 40, on economic rights, both potentially engaged by extensive commercial product regulation.

[38]Compare British American Tobacco South Africa (Pty) Ltd v Minister of Health 2012 (3) All SA 593 (SCA) (South Africa), upholding tobacco advertising restrictions against constitutional property and expression challenge.

Chapters 8 and 9: how should the six constitutional duties of Health Constitutionalism be allocated between national and local levels of government where constitutional or statutory decentralisation assigns primary implementation responsibility to sub-national units with limited independent fiscal capacity?

This chapter proposes a subsidiarity-informed allocation: the duty to regulate harmful industries, given the need for uniform national standards to prevent regulatory arbitrage between districts, and the duty to guarantee a minimum core of essential medicines, given equality considerations, are properly discharged primarily at the national level, while the duties to ensure equitable access to healthcare delivery and to guarantee community-level preventive programming are properly discharged at the local level, subject to adequate, earmarked national fiscal transfer — a framework developed in operational detail in Chapter 8's review of Uganda's Local Governments Act.[39]

2.8 Applying the Six Duties: The Insulin Illustration Revisited

Returning to the insulin illustration introduced in Chapter 1, this chapter demonstrates how each of the six Health Constitutionalism duties bears distinctly on a single governance failure. The duty to prevent disease requires investment in early type 1 diabetes diagnosis; the duty to ensure equitable access to healthcare requires that insulin, once diagnosed, be reliably available regardless of the patient's district or income; the duty to protect vulnerable populations requires particular attention to children with type 1 diabetes, for whom even brief insulin interruption carries acute, life-threatening risk; and the duty to uphold the right to the highest attainable standard of health, read through the minimum core doctrine developed in Chapter 4, supplies the doctrinal floor below which resource-constraint justification becomes unavailable.

This chapter's application demonstrates a further point of general significance: the six duties are not independent silos but operate cumulatively and often simultaneously with respect to any single governance failure, such that a litigant or policymaker addressing insulin availability, or any comparable essential-

[39]Compare the subsidiarity principle as applied in EU public health competence allocation under art 168 of the Treaty on the Functioning of the European Union, offered here as a comparative structural analogy rather than directly applicable authority.

medicine gap, is well served by pleading or designing intervention across multiple duties simultaneously, rather than selecting a single doctrinal hook.

Chapter 3 now turns to the third pillar of the theoretical framework: the Jurisprudence of Prevention, which asks how courts, having accepted the existence of positive constitutional health duties, might develop doctrinal tools capable of enforcing those duties before, rather than only after, preventable harm occurs.

CHAPTER 3
THE JURISPRUDENCE OF PREVENTION

3.1 The Limits of Reactive Law

Legal systems inherited from the common law tradition are, in their characteristic operation, reactive. Tort law compensates harm after it occurs; criminal law punishes conduct after it is committed; and even public law remedies — judicial review, constitutional damages — are typically triggered by a completed act or omission whose consequences have already crystallised.[40]

This reactive orientation is poorly suited to the epidemiology of non-communicable disease. By the time a court is presented with a completed harm — a death from lung cancer, a case of type 2 diabetes, a stroke attributable to decades of untreated hypertension — the causal chain runs back through years or decades of cumulative exposure, commercial conduct, and regulatory neglect that no after-the-fact remedy can meaningfully undo. The central question this chapter poses, and to which it proposes a doctrinal answer, is therefore stark: can constitutional law prevent disease before it occurs?

3.2 Can Constitutional Law Prevent Disease Before It Occurs?

The Jurisprudence of Prevention answers this question affirmatively, but with doctrinal precision. It does not propose that courts should displace public health expertise or dictate clinical practice. It proposes, rather, that courts should develop and apply preventive constitutional doctrines capable of compelling government to act — to regulate, to fund, to plan — before preventable illness and death occur at scale, using established comparative doctrinal tools that already exist in embryonic form across multiple jurisdictions but have not yet been systematically applied to non-communicable disease.

> *Prevention, in constitutional adjudication, is not the opposite of judicial restraint. It is the fullest expression of judicial fidelity to a constitutional text that promises life, dignity, and equality to citizens who will not survive to*

[40] On the structurally reactive orientation of common law remedies, see Guido Calabresi, The Costs of Accidents: A Legal and Economic Analysis (Yale University Press 1970), a foundational text in law-and-economics whose insights this chapter extends to the constitutional register.

enforce those promises if courts wait for harm to be completed before acting.

Four doctrinal tools, examined in turn below, together constitute the operative content of the Jurisprudence of Prevention: the precautionary principle, structural injunctions, minimum core and progressive realisation review, and the positive-obligation doctrine of state duty to protect against foreseeable third-party harm.

3.3 Preventive Doctrines: Precaution, Structural Injunction, and Anticipatory Governance

3.3.1 The Precautionary Principle

The precautionary principle, most fully developed in international environmental law, holds that where an activity raises threats of serious or irreversible harm, the absence of full scientific certainty should not be used as a reason to postpone cost-effective measures to prevent that harm.[41]

This chapter argues that the precautionary principle, though developed in the environmental context, applies with equal doctrinal force to the regulation of commercial products with well-evidenced non-communicable disease risk. Where the epidemiological evidence linking a product — tobacco being the paradigm case, ultra-processed food and sugar-sweetened beverages increasingly so — to serious and irreversible population harm reaches the threshold of scientific consensus achieved in the tobacco context, constitutional courts should treat continued regulatory inaction as presumptively unreasonable, shifting the burden to the state to justify delay.[42]

3.3.2 Structural Injunctions and Supervisory Jurisdiction

The structural injunction — a remedy requiring the state to develop, implement, and report progress against a time-bound plan to address a systemic constitutional violation, under continuing judicial supervision — has been developed most extensively in Indian and Latin American public interest litigation, and offers a template for preventive, rather than merely compensatory, judicial engagement with

[41]Rio Declaration on Environment and Development (adopted 14 June 1992) UN Doc A/CONF.151/26 (vol I), Principle 15.

[42]WHO Framework Convention on Tobacco Control (adopted 21 May 2003, entered into force 27 February 2005) 2302 UNTS 166, preamble, invoking the precautionary logic explicitly in the tobacco-control context.

non-communicable disease governance.[43]

Applied to non-communicable disease, a structural injunction might require a government found to be in systemic breach of its constitutional health duties — for example, through the sustained absence of a functioning national NCD strategic plan, or chronic under-funding of essential medicine supply chains — to develop and report against a judicially supervised implementation timetable, without the court itself specifying the substantive content of the policy, thereby respecting the separation-of-powers concern addressed in Chapter 2.

3.3.3 Minimum Core Review and Anticipatory Governance

The minimum core doctrine, introduced in Chapter 2, supplies a second preventive tool: by identifying an irreducible floor of health protection — essential medicine availability, basic screening infrastructure, clean water and sanitation — that must be satisfied immediately rather than progressively, courts can compel anticipatory state investment in the infrastructure of prevention before, rather than only after, a health crisis becomes acute.

Anticipatory governance, as a constitutional concept, extends this logic beyond litigation into ordinary legislative and administrative practice: it requires that regulatory impact assessment, budgetary planning, and legislative drafting incorporate foreseeable long-term health consequences as a mandatory consideration, analogous to environmental impact assessment, rather than as an optional or subsequently bolted-on concern.[44]

3.4 Toward a Preventive Constitutional Remedy in African Courts

This concluding section of Part I sketches, in preliminary form, how the doctrinal tools examined above might combine into a coherent preventive constitutional remedy available to African courts, including Uganda's, without requiring constitutional amendment. The proposed remedy would proceed in three

[43]On the structural injunction generally, see Owen M. Fiss, 'The Supreme Court 1978 Term — Foreword: The Forms of Justice' (1979) 93 Harvard Law Review 1; for its Latin American application, T -025 de 2004 (Constitutional Court of Colombia), discussed further in Chapter 6.

[44]Compare the environmental impact assessment model under Uganda's National Environment Act 2019, discussed further in Chapter 8, which this chapter proposes as a template for an analogous health impact assessment requirement.

stages.

At the first stage, a claimant — whether an individual litigant, a public interest organisation, or, in appropriate cases, the Human Rights Commission or Attorney General acting in the public interest — would be required to establish an evidentiary threshold: a well-documented, scientifically consensual link between a specified area of regulatory or budgetary inaction and a serious, foreseeable, population-scale health risk, analogous to the evidentiary threshold already accepted in African environmental rights litigation.[45]

At the second stage, the court would apply reasonableness review, as developed in Grootboom, to determine whether the state's existing measures — legislative, regulatory, and budgetary — constitute a reasonable response to the identified risk, giving appropriate deference to resource constraints and policy choice while insisting that some rational, evidenced programme of action exists and is being implemented in good faith.

At the third stage, where the court finds the state's response unreasonable or, with respect to minimum core obligations, non-existent, it would issue a structural remedy — a declaration of constitutional obligation coupled with a supervised implementation order — rather than attempting to specify the substantive content of health policy itself, thereby preserving the separation of powers while ensuring that the constitutional obligation to prevent disease is not left permanently unenforceable.

3.5 The Evidentiary Standard: Lessons from Environmental and Toxic Tort Litigation

The evidentiary threshold proposed in section 3.4 requires further doctrinal specification, and this chapter draws on the well-developed comparative jurisprudence of toxic tort and environmental causation to supply it. Comparative courts confronting analogous problems of diffuse, cumulative, long-latency harm — asbestos litigation, tobacco litigation, and climate change attribution science — have developed a body of technique for assessing epidemiological and statistical

[45]Compare Social and Economic Rights Action Center (SERAC) and Center for Economic and Social Rights (CESR) v Nigeria, Comm No 155/96 (African Commission on Human and Peoples' Rights, 2001), discussed fully in Chapter 5, establishing state responsibility for foreseeable environmental and health harm arising from regulatory neglect.

evidence of population-level causation that this chapter argues is directly transferable to non-communicable disease constitutional litigation.[46]

In particular, this chapter adopts the 'general causation' and 'specific causation' distinction developed in United States toxic tort jurisprudence: general causation asks whether the exposure at issue is capable of causing the type of harm alleged, established through epidemiological and biomedical evidence of the kind extensively documented by the WHO reports cited throughout this monograph, while specific causation asks whether the exposure did cause harm to a particular individual — a distinction that matters considerably less for the structural, population-level remedy proposed in this chapter than it would for individualised compensatory litigation, since a structural claim need establish only general causation at the population level.[47]

3.6 Judicial Competence and the Role of Expert Evidence

A further refinement to the Jurisprudence of Prevention concerns the practical mechanism by which courts, not typically possessing scientific or epidemiological expertise, are to assess the evidentiary threshold described above. This chapter recommends the adoption of a specialist amicus curiae or court-appointed expert panel mechanism, drawing on the WHO's and Uganda's own Ministry of Health's institutional epidemiological capacity, following the model of specialist scientific panels increasingly used in comparative environmental and public health litigation.[48]

This chapter argues that Uganda's Judicature Act already provides sufficient procedural authority for courts to appoint independent expert assessors in appropriate cases, such that this recommendation, like several others in this

[46]See generally Carl F. Cranor, Toxic Torts: Science, Law and the Possibility of Justice (2nd edn, Cambridge University Press 2016), on the evidentiary treatment of population-level, statistically established causation.

[47]Compare the general/specific causation framework applied in Daubert v Merrell Dow Pharmaceuticals, Inc, 509 US 579 (1993) (US Supreme Court), and its subsequent toxic tort application, offered here as comparative methodological guidance rather than binding Ugandan evidentiary law.

[48]Compare the expert panel mechanism used in Massachusetts v Environmental Protection Agency, 549 US 497 (2007) (US Supreme Court), addressing complex scientific causation in a public regulatory context.

monograph, requires no legislative amendment but only a shift in judicial practice and litigant strategy.[49]

3.7 Remedial Design: Avoiding the Pitfalls of Individualised Litigation

Drawing on the cautionary Colombian and Brazilian comparative experience previewed in Chapter 2 and developed fully in Chapter 6, this chapter emphasises that the Jurisprudence of Prevention's structural remedy is deliberately designed to avoid the distributive pathologies associated with purely individualised health rights litigation, in which well-resourced, litigious claimants disproportionately benefit at the expense of systemic primary and preventive care.

The three-stage framework's insistence on population-level evidentiary threshold and system-wide structural remedy, rather than individual entitlement adjudication, is therefore not merely a matter of remedial convenience but a considered response to this comparative lesson, ensuring that the Jurisprudence of Prevention strengthens, rather than potentially distorts, the equitable allocation of scarce health resources examined throughout Part III and Part IV.

This three-stage framework — evidentiary threshold, reasonableness review, structural remedy — refined in this chapter through its evidentiary, institutional, and remedial-design dimensions, constitutes the doctrinal core of the Jurisprudence of Prevention as applied to non-communicable disease. Part II now situates this framework, and the broader theory of Constitutional Epidemiology developed in this Part, within the full architecture of international, African regional, and comparative constitutional authority, before Part III applies the framework in sustained detail to Uganda.

[49] Judicature Act, Cap 13 (Uganda), s 42, on the court's power to call in the aid of assessors specially qualified.

PART II — INTERNATIONAL, REGIONAL, AND COMPARATIVE AUTHORITY

CHAPTER 4
INTERNATIONAL LAW AND THE RIGHT TO HEALTH

4.1 Article 12 ICESCR as Foundational Authority

The single most important international legal anchor for Constitutional Epidemiology is Article 12 of the International Covenant on Economic, Social and Cultural Rights, which recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and specifies that steps taken to achieve full realisation of the right shall include those necessary for the reduction of infant mortality, the improvement of environmental and industrial hygiene, the prevention, treatment, and control of epidemic, endemic, occupational, and other diseases, and the creation of conditions assuring access to medical service.[50]

Uganda ratified the ICESCR in 1987, and while the Covenant is not directly enforceable in domestic Ugandan courts absent implementing legislation, its provisions inform the interpretation of the National Objectives and Directive Principles of State Policy under Uganda's dualist constitutional tradition, and increasingly its General Comments are cited persuasively in comparative constitutional adjudication across the region, a pattern documented further in Chapter 9.[51]

4.2 General Comment No. 14: The AAAQ Framework

The Committee on Economic, Social and Cultural Rights' General Comment No. 14 supplies the single most detailed and authoritative interpretive gloss on the right to health, and its four-part Availability, Accessibility, Acceptability, and Quality (AAAQ) framework is adopted throughout this monograph as the operative standard against which state conduct is measured.[52]

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[50]International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3, art 12(1)-(2).

[51]On Uganda's dualist treatment of international treaty law, see Attorney General v Uganda Law Society [2020] UGSC (Supreme Court of Uganda), applying the Constitution's dualist framework under art 123.

[52]UN Committee on Economic, Social and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) UN Doc E/C.12/2000/4 (11 August 2000) paras 12(a)-

Availability requires that functioning public health and healthcare facilities, goods, and services, together with underlying determinants of health such as safe water and adequate sanitation, exist in sufficient quantity. Accessibility requires that these be accessible to everyone without discrimination, encompassing physical accessibility, economic accessibility (affordability), and information accessibility. Acceptability requires respect for medical ethics and cultural appropriateness. Quality requires that facilities, goods, and services be scientifically and medically appropriate and of good quality.

General Comment No. 14 further elaborates the state's tripartite obligation to respect, protect, and fulfil the right to health — a structure this monograph adopts directly into the six constitutional duties of Health Constitutionalism developed in Chapter 2, with the duty to regulate harmful industries corresponding most closely to the obligation to protect against third-party interference with the enjoyment of the right to health.[53]

4.3 The Minimum Core Obligation

General Comment No. 3 establishes that states parties have a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each Covenant right, an obligation that persists irrespective of resource constraints and is not subject to progressive realisation.[54]

General Comment No. 14 specifies the minimum core content of the right to health to include essential primary healthcare, minimum essential food, basic shelter and sanitation, essential drugs as periodically defined by the WHO Action Programme on Essential Drugs, equitable distribution of health facilities, and a national public health strategy addressing the health concerns of the whole population.[55]

(d).

[53]General Comment No 14 (n above) paras 33-37, on the obligation to protect, including the specific duty to 'control the marketing of medical equipment and medicines by third parties' and, by extension in this monograph's argument, other health-harming commercial products.

[54]UN Committee on Economic, Social and Cultural Rights, General Comment No. 3: The Nature of States Parties' Obligations UN Doc E/1991/23 (14 December 1990) para 10.

[55]General Comment No 14 (n above) para 43(a)-(f).

This monograph argues that essential non-communicable disease medicines — insulin, basic chemotherapeutic agents, antihypertensives, and dialysis access for acute renal failure — fall squarely within this minimum core, such that their sustained unavailability constitutes a violation not subject to a resource-constraint defence, a proposition tested against Ugandan practice in Chapter 8.

4.4 The WHO Framework Convention on Tobacco Control

The WHO Framework Convention on Tobacco Control, ratified by Uganda in 2007, is the most fully developed international legal instrument addressing a single non-communicable disease risk factor, and offers a template this monograph argues should be extended, mutatis mutandis, to sugar-sweetened beverages and ultra-processed food.[56]

The Convention's key obligations — price and tax measures to reduce demand (Article 6), protection from exposure to tobacco smoke (Article 8), regulation of the contents and disclosures of tobacco products (Articles 9-10), packaging and labelling requirements (Article 11), and a comprehensive ban on tobacco advertising, promotion, and sponsorship (Article 13) — collectively demonstrate that international law already accepts the legitimacy of comprehensive, multi-instrument regulatory intervention against a commercially produced non-communicable disease risk, undermining any suggestion that such regulation is constitutionally exceptional or disproportionate.[57]

4.5 The Global NCD Framework

The 2011 UN General Assembly Political Declaration on the Prevention and Control of Non-Communicable Diseases, and the subsequent WHO Global Action Plan for the Prevention and Control of NCDs 2013-2030, together constitute the principal soft-law architecture directly addressing the non-communicable disease burden, and supply the '25 by 25' and subsequent Sustainable Development Goal target 3.4 commitments — a one-third reduction in premature NCD mortality by 2030 — against which state performance, including Uganda's, is assessed throughout Part

[56]WHO Framework Convention on Tobacco Control (adopted 21 May 2003, entered into force 27 February 2005) 2302 UNTS 166.

[57]WHO FCTC (n above) arts 6, 8-11, 13.

III.[58]

While these instruments are not binding treaty law, this monograph argues, consistently with the reasonableness-review doctrine developed in Chapter 2, that they supply the evidentiary and normative benchmark against which the reasonableness of state action — or inaction — is properly measured in domestic constitutional adjudication, in the same manner that international environmental soft law has been deployed by comparative courts assessing environmental reasonableness.

4.6 Children's and Women's Rights Instruments

The Convention on the Rights of the Child obliges states to recognise the child's right to the highest attainable standard of health, and specifically to take appropriate measures to combat disease and malnutrition, develop preventive healthcare, and ensure that all segments of society have access to health education.[59]

The Convention on the Elimination of All Forms of Discrimination against Women similarly obliges states to eliminate discrimination against women in access to healthcare, with particular reference to family planning, and to ensure appropriate services in connection with pregnancy — provisions of direct relevance to the gendered dimensions of the non-communicable disease burden examined in Chapter 12.[60]

4.7 The International Health Regulations and Cross-Cutting Governance

The International Health Regulations (2005), while principally addressed to communicable disease and public health emergencies of international concern, contain a broader institutional architecture for national health governance capacity —

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[58]UN General Assembly, Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases UN Doc A/RES/66/2 (2011); WHO, Global Action Plan for the Prevention and Control of NCDs 2013-2030 (WHO, Geneva 2013); UN Sustainable Development Goals, target 3.4.

[59]Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3, art 24.

[60]Convention on the Elimination of All Forms of Discrimination against Women (adopted 18 December 1979, entered into force 3 September 1981) 1249 UNTS 13, art 12.

surveillance, reporting, and core capacity requirements — that this chapter argues supplies a useful template for the NCD-specific surveillance and reporting architecture recommended throughout Part III and Part IV.[61]

4.8 Trade Law and Public Health: The WTO Framework

International trade law, principally the WTO Agreement on Technical Barriers to Trade and the General Agreement on Tariffs and Trade, intersects significantly with the domestic regulatory measures this monograph recommends — front-of-pack labelling, marketing restriction, and taxation — and this chapter examines the extent to which such measures are shielded from trade-law challenge.[62]

The WTO Appellate Body's decision in Australia — Plain Packaging, examined further in Chapter 2's discussion of proportionality, together with the broader jurisprudence upholding public health-motivated trade restrictions under GATT Article XX(b)'s general exception for measures necessary to protect human life or health, establishes with reasonable clarity that the domestic NCD regulatory measures recommended throughout this monograph are unlikely to face insurmountable trade-law obstacles, provided they are non-discriminatory and supported by adequate scientific evidence.[63]

4.9 Human Rights Council and Special Procedures

The UN Human Rights Council's Special Rapporteur on the right to physical and mental health has, in successive thematic reports, addressed the commercial determinants of non-communicable disease directly, calling on states to regulate the food, alcohol, and tobacco industries as a matter of human rights obligation rather than discretionary public health policy — a normative framing this monograph adopts and applies systematically throughout Parts III and IV.[64]

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[61]International Health Regulations (2005), World Health Assembly Resolution WHA58.3 (23 May 2005), arts 5-6, on surveillance and core capacity requirements.

[62]Agreement on Technical Barriers to Trade (1994), incorporated into the WTO Agreement, art 2.2, permitting technical regulations necessary to fulfil a legitimate objective including the protection of human health.

[63]General Agreement on Tariffs and Trade 1994, art XX(b); Australia — Plain Packaging (n above).

[64]UN Human Rights Council, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, UN Doc A/74/174 (2019), addressing unhealthy food environments and the right to health.

Chapter 5 now turns from the international to the African regional plane, examining the African Charter on Human and Peoples' Rights and its interpretive jurisprudence as the second major pillar of authority for Constitutional Epidemiology.

CHAPTER 5
AFRICAN REGIONAL AUTHORITY

5.1 The African Charter on Human and Peoples' Rights

The African Charter on Human and Peoples' Rights, ratified by Uganda in 1986, supplies the principal regional human rights framework within which Constitutional Epidemiology is situated. Four provisions are of particular significance: Article 4 (right to life and integrity of the person), Article 5 (dignity and freedom from cruel, inhuman, or degrading treatment), Article 16 (right to enjoy the best attainable state of physical and mental health), and Article 24 (right of peoples to a general satisfactory environment favourable to their development).[65]

Article 16 is distinctive among regional human rights instruments in its explicit textual guarantee of a right to health, obliging states parties to 'take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick' — language this monograph reads as encompassing both curative and, through the reference to protection, preventive obligation.[66]

5.2 SERAC v Nigeria: The Foundational Precedent

The African Commission's decision in Social and Economic Rights Action Center and Center for Economic and Social Rights v Nigeria — the Ogoniland case — is the single most important African regional precedent for Constitutional Epidemiology, and is examined here in some detail.[67]

The communication alleged that the Nigerian government, through its collaboration with oil consortiums operating in Ogoniland, had caused and permitted environmental degradation and health crises resulting from oil-related pollution, and had failed to protect the Ogoni people from the harmful effects of that pollution. The African Commission found violations of Articles 4, 16, and 24, holding that the right

[65]African Charter on Human and Peoples' Rights (adopted 27 June 1981, entered into force 21 October 1986) 1520 UNTS 217, arts 4, 5, 16, 24.

[66]African Charter (n above) art 16(1)-(2).

[67]Social and Economic Rights Action Center (SERAC) and Center for Economic and Social Rights (CESR) v Nigeria, Comm No 155/96 (African Commission on Human and Peoples' Rights, 27 October 2001).

to a general satisfactory environment imposes clear obligations upon governments, including reasonable measures to prevent pollution and ecological degradation, and that the right to health is compromised where a government fails to prevent contamination of water, soil, and food.

> *Governments have a duty to protect their citizens, not only through appropriate legislation and effective enforcement but also by protecting them from damaging acts that may be perpetrated by private parties.*

This holding — that the state's obligation extends to protection from harm caused by third parties, including commercial actors, and that regulatory failure to prevent foreseeable environmental and health harm constitutes an independent human rights violation — supplies the clearest existing African precedent for the duty to regulate harmful industries central to Health Constitutionalism, and this monograph argues that its logic extends directly, without material distinction, from oil pollution to the commercial determinants of non-communicable disease.[68]

5.3 The Maputo Protocol

The Protocol to the African Charter on the Rights of Women in Africa (the Maputo Protocol), ratified by Uganda in 2010, obliges states to ensure women's right to health, including sexual and reproductive health, and specifically to provide adequate, affordable, and accessible healthcare services, including information, education, and communication programmes to women, especially those in rural areas.[69]

Article 14's specific reference to nutrition and the elimination of harmful practices affecting women's health is of direct relevance to the gendered non-communicable disease burden — particularly cervical cancer, gestational diabetes, and hypertensive disorders of pregnancy — examined further in Chapter 12.

5.4 The African Charter on the Rights and Welfare of the Child

The African Charter on the Rights and Welfare of the Child, ratified by Uganda in 1994, guarantees the child's right to enjoy the best attainable state of physical,

[68]SERAC v Nigeria (n above) paras 52-58, 60-66.

[69]Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (adopted 11 July 2003, entered into force 25 November 2005) art 14.

mental, and spiritual health, and obliges states to take measures to diminish infant and child mortality, ensure the provision of necessary medical assistance, combat disease and malnutrition, and ensure the provision of adequate nutrition and safe drinking water.[70]

This provision is of particular significance for the childhood obesity and paediatric NCD risk-factor accumulation examined in Chapter 10's treatment of the commercial determinants of health, particularly the marketing of unhealthy food and beverages to children.

5.5 Africa CDC and African Union Health Governance

The African Union's continental health architecture, principally the Africa Centres for Disease Control and Prevention (Africa CDC) and the African Union's Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa, has historically concentrated resources and institutional capacity on infectious disease, a pattern this monograph identifies as itself a manifestation of the constitutional and institutional under-prioritisation of non-communicable disease governance addressed throughout this book.[71]

More recent Africa CDC strategic documents have begun to incorporate NCD surveillance and response into continental health security architecture, a development this monograph welcomes as consistent with the reframing of NCDs as a security concern developed in Chapter 16, while noting that institutional and financing reform remains substantially incomplete.

5.6 The African Commission's Health-Related Jurisprudence Beyond SERAC

Beyond SERAC, the African Commission on Human and Peoples' Rights has developed a body of jurisprudence and soft-law guidance relevant to health governance, including its Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter, which elaborate the

[70]African Charter on the Rights and Welfare of the Child (adopted 11 July 1990, entered into force 29 November 1999) art 14.

[71]African Union, Africa Health Strategy 2016-2030 (African Union Commission 2016), acknowledging the rising NCD burden while documenting the continued institutional and financing emphasis on infectious disease.

AAAQ framework in terms substantially consonant with General Comment No. 14, and its resolutions on access to health and needed medicines.[72]

Taken together, the African Charter, the Maputo Protocol, the African Children's Charter, and the SERAC precedent supply a substantial and under-utilised body of regional authority capable of supporting the doctrines of Health Constitutionalism and the Jurisprudence of Prevention within domestic Ugandan and comparable African constitutional adjudication, a potential this monograph argues has not yet been realised in practice, a gap examined further in Chapter 9's review of Ugandan judicial practice.

5.7 The East African Community Legal Framework

The Treaty for the Establishment of the East African Community obliges partner states, including Uganda, to cooperate in health matters, and the East African Community's Protocol on Environment and Natural Resources Management contains provisions on cross-border pollution of direct relevance to the environmental determinants of health examined in Chapter 14, given the Lake Victoria basin's shared and heavily industrialised catchment.[73]

This chapter recommends that Uganda pursue harmonised East African Community standards for food labelling, tobacco and alcohol taxation, and industrial emissions, both to prevent regulatory arbitrage — whereby manufacturers relocate marketing or production to the jurisdiction with the weakest standards — and to strengthen the collective bargaining position of East African states relative to multinational food, alcohol, and tobacco manufacturers, a dynamic well documented in the comparative literature on regional regulatory harmonisation.[74]

5.8 The African Court on Human and Peoples' Rights

The African Court on Human and Peoples' Rights, established under the 1998

[72]African Commission on Human and Peoples' Rights, Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights (2011), paras 66-73 on the right to health.

[73]Treaty for the Establishment of the East African Community (1999, as amended), art 118 (health cooperation); Protocol on Environment and Natural Resources Management (2006).

[74]Compare the harmonisation rationale underlying EU tobacco product regulation, Directive 2014/40/EU, offered as a comparative institutional model for East African Community harmonisation.

Ouagadougou Protocol, possesses jurisdiction to interpret and apply the African Charter, the Maputo Protocol, and the African Children's Charter, and its still-developing jurisprudence offers, this chapter argues, an important complementary forum to the African Commission's SERAC precedent for future NCD-related regional litigation, notwithstanding Uganda's own contested history with the Court's direct individual-complaint jurisdiction.[75]

5.9 Regional Economic Communities and Health Harmonisation

Beyond the East African Community, the wider African Continental Free Trade Area framework, and its ongoing protocol negotiations on trade in services including health-related services, present both an opportunity and a risk this chapter flags for future research: an opportunity for harmonised regional NCD prevention standards, and a risk that trade liberalisation without accompanying regulatory harmonisation could weaken, rather than strengthen, national NCD regulatory capacity through increased market penetration by multinational tobacco, alcohol, and food conglomerates.[76]

Chapter 6 now turns to comparative constitutional jurisprudence beyond the African region, examining South Africa, Kenya, India, Colombia, Brazil, the United States, and the United Kingdom as sources of doctrinal technique applicable, with appropriate adaptation, to the Ugandan and African context.

[75]Protocol to the African Charter on Human and Peoples' Rights on the Establishment of an African Court on Human and Peoples' Rights (adopted 10 June 1998, entered into force 25 January 2004).

[76]Agreement Establishing the African Continental Free Trade Area (2018), ongoing Protocol on Trade in Services negotiations, noted here as an area warranting dedicated future research attention.

CHAPTER 6
COMPARATIVE CONSTITUTIONALISM

6.1 South Africa: The Reasonableness Model

The Constitution of the Republic of South Africa, 1996 remains the most textually generous comparative model for Health Constitutionalism, expressly guaranteeing the right to have access to healthcare services, including reproductive healthcare, sufficient food and water, and an environment not harmful to health or well-being, together with a specific right for children to basic healthcare services.[77]

In Soobramoney v Minister of Health, KwaZulu-Natal, the Constitutional Court declined to order a public hospital to provide ongoing dialysis treatment to a patient with chronic renal failure who did not meet the hospital's resource-based eligibility guidelines, holding that the state's obligations under section 27 must be understood in light of its available resources, and that courts should be slow to second-guess bona fide rationing decisions made by medical authorities.[78]

Soobramoney is frequently read as a defeat for socio-economic rights litigants; this monograph reads it more precisely as establishing the outer boundary of judicial deference — a boundary this book argues is appropriately narrower where, unlike in Soobramoney, the challenge is not to an individualised clinical rationing decision but to a systemic, population-scale regulatory or budgetary failure of the kind addressed by Constitutional Epidemiology.

Government of the Republic of South Africa v Grootboom developed the reasonableness review standard that this monograph adopts as the second stage of its proposed three-stage preventive remedy in Chapter 3: the question is not whether the state has done everything possible, but whether its programme is reasonable, taking into account the availability of resources, and whether it makes reasonable provision for those in desperate need.[79]

Minister of Health v Treatment Action Campaign (No 2) applied and extended

[77]Constitution of the Republic of South Africa, 1996, ss 24, 27, 28(1)(c).

[78]Soobramoney v Minister of Health, KwaZulu-Natal 1998 (1) SA 765 (CC).

[79]Government of the Republic of South Africa v Grootboom 2001 (1) SA 46 (CC) paras 41-44, 99.

Grootboom in the health context specifically, ordering the government to remove restrictions preventing the administration of nevirapine to prevent mother-to-child HIV transmission in the public health sector, and to develop a comprehensive programme for its progressive realisation — a structural remedy this monograph treats as the clearest existing comparative precedent for the structural injunction proposed in Chapter 3.[80]

6.2 Kenya: Express Health Rights and Public Interest Litigation

The Constitution of Kenya, 2010 guarantees every person the right to the highest attainable standard of health, including reproductive healthcare, and the right to emergency medical treatment that shall not be refused, together with the right to a clean and healthy environment.[81]

Kenyan courts have developed a comparatively liberal approach to public interest standing in socio-economic rights litigation, and Kenyan jurisprudence on the right to a clean and healthy environment — including the principle that any person may bring an action alleging environmental harm without proof of personal loss or injury — offers a template this monograph argues is directly transplantable to Uganda's own, currently more restrictively interpreted, environmental and public interest standing rules.[82]

6.3 India: The Expansive Right to Life

Article 21 of the Constitution of India guarantees that no person shall be deprived of life or personal liberty except according to procedure established by law — text considerably sparer than South Africa's or Kenya's, yet interpreted by the Supreme Court of India to encompass an expansive range of socio-economic entitlements through purposive construction.[83]

In Francis Coralie Mullin v Administrator, Union Territory of Delhi, the Supreme Court held that the right to life includes the right to live with human dignity,

[80]Minister of Health v Treatment Action Campaign (No 2) 2002 (5) SA 721 (CC) paras 78-80, 135.

[81]Constitution of Kenya, 2010, arts 43(1)(a), 43(2), 42.

[82]Environmental Management and Co-ordination Act 1999 (Kenya), s 3(3)-(4); discussed further in Chapter 9's comparative analysis of Ugandan standing rules.

[83]Constitution of India, art 21.

encompassing adequate nutrition, clothing, shelter, and facilities for reading, writing, and expressing oneself — an interpretive method this monograph argues supplies the most directly applicable comparative technique for Uganda, whose Article 22 right to life is textually similar in its economy to the Indian provision.[84]

Subsequent Indian jurisprudence has extended Article 21 specifically to environmental and health protection, holding in M.C. Mehta v Union of India that the right to life includes the right to a healthy environment, and developing through a succession of public interest litigation cases a jurisprudence of structural, continuing -mandamus remedies of direct relevance to the Jurisprudence of Prevention developed in Chapter 3.[85]

6.4 Colombia and Brazil: Structural Health Litigation

The Constitutional Court of Colombia's decision in T-025 de 2004, addressing the systemic failure of the state to protect internally displaced persons, established the structural injunction as a distinctive Latin American constitutional remedy: rather than resolving individual claims, the Court declared an 'unconstitutional state of affairs' and retained supervisory jurisdiction over a multi-year, multi-agency implementation process.[86]

Colombian health rights litigation more specifically has produced an extraordinarily high volume of individual tutela actions compelling the provision of medicines and treatment, prompting the Constitutional Court in decision T-760 de 2008 to adopt structural remedies addressing systemic deficiencies in the health system as a whole, rather than continuing to process individual claims piecemeal — a cautionary precedent this monograph discusses as illustrating both the power and the potential dysfunction of purely individualised health rights litigation absent the systemic, preventive orientation Constitutional Epidemiology proposes.[87]

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[84]Francis Coralie Mullin v Administrator, Union Territory of Delhi (1981) 1 SCC 608 (Supreme Court of India).

[85]M.C. Mehta v Union of India AIR 1987 SC 1086 (Supreme Court of India); see also Vellore Citizens' Welfare Forum v Union of India (1996) 5 SCC 647, explicitly adopting the precautionary principle into Indian constitutional environmental jurisprudence.

[86]T-025 de 2004 (Constitutional Court of Colombia, 22 January 2004).

[87]T-760 de 2008 (Constitutional Court of Colombia, 31 July 2008).

Brazil's experience with judicialização da saúde — the judicialisation of health — under Article 196 of its 1988 Constitution presents a parallel cautionary tale: extensive individual litigation compelling the provision of specific, often high-cost medicines has, on substantial empirical evidence, sometimes distorted health budget priorities in favour of litigious, better-resourced claimants at the expense of systemic primary and preventive care — a distributive concern this monograph takes seriously in calibrating the Jurisprudence of Prevention toward systemic, structural remedies rather than individualised entitlement litigation.[88]

6.5 The United States: The Limits of Constitutional Health Protection

The United States Constitution contains no express right to health or healthcare, and the Supreme Court has consistently declined to read such a right into the Due Process Clause, most notably in DeShaney v Winnebago County Department of Social Services, holding that the Due Process Clause generally confers no affirmative right to governmental aid, even where such aid may be necessary to secure life, liberty, or property interests.[89]

The American experience is instructive by contrast: it demonstrates that in the absence of express constitutional textual commitment or a judicially developed doctrine of positive obligation, health protection is left almost entirely to ordinary legislative and regulatory politics, subject to capture by well-resourced commercial interests — the tobacco, alcohol, and processed food industries prominent among them — a pattern this monograph argues Constitutional Epidemiology is specifically designed to guard against through entrenched, judicially enforceable constitutional duty.

6.6 The United Kingdom: Parliamentary Regulation Without Constitutional Entrenchment

The United Kingdom's uncodified constitution and doctrine of parliamentary sovereignty preclude the direct constitutional entrenchment of health rights, yet the UK has nonetheless achieved substantial non-communicable disease regulatory

[88]Octavio Luiz Motta Ferraz, 'Harming the Poor through Social Rights Litigation: Lessons from Brazil' (2011) 89 Texas Law Review 1643.

[89]DeShaney v Winnebago County Department of Social Services, 489 US 189 (1989).

success through ordinary legislation — the Health and Social Care Act 2012's tobacco display restrictions, the Soft Drinks Industry Levy 2018 (the 'sugar tax'), and comprehensive smoke-free legislation under the Health Act 2006.[90]

The UK experience demonstrates that constitutional entrenchment, while this monograph argues it materially strengthens durability and enforceability, is not strictly indispensable to preventive regulatory achievement where political and institutional culture — itself, this book argues, a downstream product of long-run constitutional practice — independently supports evidence-based public health regulation. The comparative lesson for Uganda, developed in Part III, is that constitutional reform and ordinary legislative and regulatory reform are complementary rather than substitutable strategies.

6.7 Synthesising the Comparative Lessons

Five comparative lessons emerge from this chapter's survey, each carried forward into the Ugandan case study of Part III. First, express constitutional textual guarantee of a health right, as in South Africa and Kenya, materially strengthens justiciability but is not strictly necessary given the interpretive technique available under an expansive right-to-life doctrine, as India demonstrates. Second, reasonableness review, rather than direct judicial specification of policy, is the doctrinally appropriate standard for adjudicating positive health duties. Third, structural remedies are more capable than individualised litigation of addressing the systemic character of non-communicable disease risk, and better guard against the regressive distributive effects observed in Colombia and Brazil. Fourth, the absence of constitutional entrenchment, as in the United States and the United Kingdom, leaves health regulation vulnerable to commercial capture, though the UK's experience shows ordinary legislation can achieve significant results where political culture supports it. Fifth, environmental and health rights are increasingly treated as doctrinally intertwined across jurisdictions, a convergence of direct relevance to Uganda's own Article 39 right to a clean and healthy environment, examined in Chapter 7.

[90] Health Act 2006 (UK), Part 1; Finance Act 2017 (UK), Part 2 (Soft Drinks Industry Levy).

6.8 Nigeria and Ghana: West African Comparators

Nigeria's 1999 Constitution, like Uganda's, relegates health provision to a non-justiciable directive principle under Chapter II, yet Nigerian courts have, in a limited but growing body of jurisprudence, permitted directive principles to inform the interpretation of the justiciable right to life and dignity under Chapter IV, a jurisprudential trend closely paralleling this monograph's proposed approach to Uganda's own National Objectives and Directive Principles examined in Chapter 7.[91]

Ghana's 1992 Constitution similarly contains non-justiciable Directive Principles of State Policy alongside justiciable fundamental rights, and Ghana's more developed statutory traditional medicine registration framework, examined further in Chapter 15, together with its National Health Insurance Scheme, offers instructive comparative lessons for Uganda's own pending health insurance and traditional medicine legislation.[92]

6.9 Rwanda: Community-Based Health Financing

Rwanda's community-based health insurance scheme, Mutuelles de Santé, achieving among the highest health insurance coverage rates in sub-Saharan Africa, offers a financing model this chapter examines as a potential template for Uganda's own pending National Health Insurance Scheme legislation, examined in Chapter 16, notwithstanding significant differences in population scale and administrative capacity between the two states.[93]

6.10 The European Convention System: Positive Obligation Doctrine in Detail

This chapter returns, in greater doctrinal depth than the brief reference in Chapter 2, to the European Court of Human Rights' positive obligation jurisprudence under Article 2 (right to life) and Article 8 (private and family life) of the European Convention on Human Rights, which has been extended in a substantial line of cases

[91]Constitution of the Federal Republic of Nigeria 1999, ss 6(6)(c) (non-justiciability of Chapter II), 33 (right to life), 34 (dignity); compare Registered Trustees of the Social Economic Rights and Accountability Project v Federal Republic of Nigeria, ECW/CCJ/APP/0808 (ECOWAS Community Court of Justice, 2010), permitting a directive-principle-informed reading of the right to education.

[92]Constitution of the Republic of Ghana 1992, ch 6 (Directive Principles); National Health Insurance Act 2012 (Ghana).

[93]Agnes Binagwaho and others, 'Rwanda 20 Years On: Investing in Life' (2014) 384 The Lancet 371, documenting the Mutuelles de Santé scheme's coverage outcomes.

to environmental and industrial health hazard contexts closely analogous to the non-communicable disease governance failures examined throughout this monograph.[94]

These cases collectively establish that positive obligation doctrine, even within a regional human rights system with no express textual health right, is capable of sophisticated application to industrial and environmental health hazard, supplying further comparative confirmation of this monograph's central claim that Uganda's own textually sparse but interpretively rich constitutional provisions are capable of sustaining an equivalent doctrinal development.

Part III now turns to Uganda itself, applying the theoretical framework of Part I and the comparative and international authority of Part II to a sustained examination of Uganda's constitutional text, statutory and policy framework, and institutional and judicial practice.

[94]López Ostra v Spain App No 16798/90 (ECtHR, 9 December 1994), finding a violation of art 8 where the state failed to take reasonable measures to protect against harmful industrial pollution affecting the applicant's health; Öneryıldız v Turkey App No 48939/99 (ECtHR, 30 November 2004), extending art 2 positive obligation to a foreseeable industrial disaster.

PART III — UGANDA AS CASE STUDY

CHAPTER 7
UGANDA'S CONSTITUTIONAL TEXT AND HEALTH GOVERNANCE

7.1 The Absence of an Express Health Right

The Constitution of the Republic of Uganda, 1995 (as amended) contains no standalone, directly justiciable right to health comparable to South Africa's section 27 or Kenya's Article 43. This textual absence has, in this monograph's assessment, contributed materially to the underdevelopment of health-related constitutional litigation in Uganda relative to its regional comparators, a pattern documented empirically in Chapter 9.[95]

This chapter argues, however, consistently with the Indian comparative model examined in Chapter 6, that this textual absence is not fatal to the doctrines of Health Constitutionalism and the Jurisprudence of Prevention. Uganda's Constitution contains a sufficiently rich constellation of rights and directive principles capable of grounding an expansive, purposive reading of constitutional health obligation, a reading this chapter develops provision by provision.

7.2 The Right to Life: Article 22

Article 22(1) of the Constitution provides that no person shall be deprived of life intentionally except in execution of a sentence passed in a fair trial by a court of competent jurisdiction in respect of a criminal offence under Ugandan law of which the person has been convicted.[96]

While Article 22's text is framed principally in negative terms — protection against intentional deprivation of life by the state — this chapter argues, following the Indian interpretive method examined in Chapter 6, that the right to life is properly read to encompass the conditions necessary for a dignified life, including protection from foreseeable, preventable death arising from regulatory neglect. This reading finds support in the Constitutional Court's own jurisprudence recognising that

[95]Compare the express health rights in Constitution of the Republic of South Africa, 1996, s 27, and Constitution of Kenya, 2010, art 43, with the absence of an equivalent provision in the Constitution of the Republic of Uganda, 1995 (as amended).

[96]Constitution of the Republic of Uganda, 1995 (as amended), art 22(1).

constitutional rights must be interpreted purposively and in light of Uganda's international obligations, discussed further in section 7.6 below.[97]

7.3 Dignity, Equality, and Non-Discrimination

Article 24 prohibits torture, cruel, inhuman, or degrading treatment or punishment, and this monograph argues that a state's sustained, foreseeable failure to prevent an epidemic of preventable non-communicable disease among an identifiable population — for instance, the persistent unavailability of insulin resulting in preventable diabetic deaths — may, in extreme and sustained cases, approach the threshold of inhuman treatment through omission, an argument developed further with reference to comparative positive-obligation doctrine in section 7.6.[98]

Article 21 guarantees equality before the law and freedom from discrimination, a provision of particular relevance to the socio-economic and geographic disparities in non-communicable disease risk and treatment access documented in Chapter 12 — disparities between urban and rural populations, and between wealthy and poor households, in access to insulin, dialysis, and cancer treatment.[99]

7.4 The Right to a Clean and Healthy Environment: Article 39

Article 39 provides that every Ugandan has a right to a clean and healthy environment — the Constitution's single most directly relevant textual health-adjacent provision, and one this monograph argues has been substantially under-litigated relative to its doctrinal potential.[100]

Read alongside the National Environment Act 2019's broad standing provisions, permitting any person to bring an action against another person for an act which is or is likely to be harmful to the environment without proof of personal loss, Article 39 provides substantial doctrinal resources for litigation addressing air

[97]See Constitutional Court practice on purposive interpretation generally, eg Attorney General v Salvatori Abuki [1999] UGCC (Constitutional Court of Uganda), applying a purposive approach to constitutional rights interpretation.

[98]Constitution of the Republic of Uganda, 1995 (as amended), art 24.

[99]Constitution of the Republic of Uganda, 1995 (as amended), art 21.

[100]Constitution of the Republic of Uganda, 1995 (as amended), art 39.

pollution, industrial contamination, and other environmental determinants of cardiovascular, respiratory, and renal disease examined in Chapter 14.[101]

7.5 The National Objectives and Directive Principles of State Policy

Uganda's National Objectives and Directive Principles of State Policy, a distinctive feature of the Constitution's drafting tradition shared with several Commonwealth African constitutions, contain the most extensive textual health-related material in the Constitution, notwithstanding Article 8A and the Directive Principles' own terms, which render them non-justiciable in the direct sense but binding on all organs and agencies of the state and all citizens in the performance of their functions.[102]

Objective XX specifically provides that the state shall take all practical measures to ensure the provision of basic medical services to the population, and Objective XIV commits the state to ensuring that all Ugandans enjoy rights and opportunities and access to health services. While not directly justiciable, this chapter argues, consistently with comparative Indian and Nigerian directive-principle jurisprudence, that these objectives are properly deployed as an interpretive aid informing the content of the justiciable rights examined above — a technique the Supreme Court of Uganda has itself endorsed in other contexts.[103]

7.6 Article 45 and the Non-Exclusion of Other Rights

Article 45 provides that the rights, duties, declarations, and guarantees relating to the fundamental and other human rights and freedoms specifically mentioned in the Constitution shall not be regarded as excluding others not specifically mentioned. This chapter argues that Article 45, read together with Article 22's right to life and the Directive Principles' health objectives, supplies an independent textual basis for recognising an unenumerated but constitutionally

[101]National Environment Act 2019 (Uganda), s 4, on public interest environmental litigation.

[102]Constitution of the Republic of Uganda, 1995 (as amended), National Objectives and Directive Principles of State Policy, Objective XIV (general social and economic objectives), Objective XX (medical services); art 8A.

[103]Compare the Indian Supreme Court's treatment of Directive Principles as an interpretive aid to fundamental rights in Minerva Mills Ltd v Union of India AIR 1980 SC 1789, a technique this monograph argues is directly applicable to Uganda's structurally similar constitutional design.

protected interest in health protection, following the interpretive logic of the Indian and South African courts' treatment of analogous residual and expansive rights clauses.[104]

7.7 Article 8A and National Interest

Article 8A, introduced by constitutional amendment, provides that Uganda shall be governed based on principles of national interest and common good enshrined in the National Objectives and Directive Principles of State Policy. This monograph argues that Article 8A's elevation of the Directive Principles to a governing constitutional principle, rather than a merely aspirational preamble, strengthens the interpretive weight properly accorded to Objective XX's health provisions in the reading of Articles 22, 24, and 39 advanced in this chapter.[105]

7.8 Synthesis: A Composite Constitutional Health Duty

This chapter's textual analysis supports the conclusion that, notwithstanding the absence of an express standalone health right, the Constitution of Uganda contains sufficient textual material — Articles 21, 22, 24, 39, and 45, read together with Article 8A and Objectives XIV and XX of the National Objectives and Directive Principles of State Policy — to ground a composite constitutional duty of health protection consonant with the six duties of Health Constitutionalism developed in Chapter 2.

7.9 Article 20 and the Inherent Nature of Rights

Article 20(1) declares that fundamental rights and freedoms of the individual are inherent and not granted by the state, a provision this chapter reads as reinforcing the purposive, expansive interpretive method advocated throughout this chapter, since an inherent-rights framing counsels against a narrowly textualist reading that would treat the absence of an express health right as dispositive of the absence of health-related constitutional obligation.[106]

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[104]Constitution of the Republic of Uganda, 1995 (as amended), art 45.

[105]Constitution of the Republic of Uganda, 1995 (as amended), art 8A, inserted by the Constitution (Amendment) Act 2005.

[106]Constitution of the Republic of Uganda, 1995 (as amended), art 20(1).

7.10 The 1995 Constitution-Making Process and Its Health Provisions

The Odoki Commission's report, preceding the 1995 Constitution's enactment, recorded extensive public submissions calling for an express constitutional right to health, submissions the Constituent Assembly ultimately did not adopt in the form of a standalone justiciable provision, instead distributing health-related commitments across the National Objectives and Directive Principles examined in section 7.5.[107]

This chapter argues that this drafting history, rather than foreclosing the composite constitutional health duty developed in this chapter, in fact supports it: the Constituent Assembly's placement of health commitments within the Directive Principles reflected a considered judgment that health protection was a constitutional priority, differing from the South African and Kenyan drafters only in the interpretive mechanism chosen — directive principle rather than justiciable right — a difference of form this chapter's purposive analysis, drawing on Article 8A's subsequent elevation of the Directive Principles, argues should not be treated as a difference of substantive constitutional commitment.

7.11 Proposals for Constitutional Amendment

While this monograph's central argument, developed throughout Part III, is that existing constitutional text is sufficient to ground the composite health duty without amendment, this chapter nonetheless considers, as a complementary long-term reform, the case for a future constitutional amendment introducing an express, justiciable right to health modelled on Kenya's Article 43, which would remove any residual interpretive uncertainty and align Uganda's constitutional text more closely with the doctrinal architecture this monograph has developed.[108]

This chapter treats such amendment as a desirable long-term aspiration rather than a precondition for the judicial and legislative reforms recommended throughout this monograph, consistent with the pragmatic, incrementalist strategy that has characterised the successful comparative examples examined in Chapter 6.

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[107]Uganda Constitutional Commission, Report of the Uganda Constitutional Commission: Analysis and Recommendations (1993) paras 4.180-4.195, documenting public submissions on health rights during the constitution-making process.

[108]Compare the amendment process under Constitution of the Republic of Uganda, 1995 (as amended), art 259, applicable to amendment of the Bill of Rights provisions.

Chapter 8 now turns from constitutional text to the statutory and policy framework through which this composite constitutional duty is, or is not, operationalised in Ugandan law and practice, before Chapter 9 examines the institutional and judicial record of enforcement.

CHAPTER 8
STATUTORY AND POLICY FRAMEWORK

8.1 The Public Health Act

Uganda's Public Health Act, substantially unrevised since the colonial period notwithstanding subsequent amendment, remains the principal statutory framework for public health regulation, conferring broad powers on the Minister of Health and local authorities to prevent and guard against the introduction of infectious disease, but containing comparatively limited provision addressing non-communicable disease risk factors.[109]

This chapter argues that the Public Health Act's infectious-disease orientation is itself a manifestation of the constitutional neglect thesis developed in Chapter 1: the statute's structure reflects and entrenches a governance model calibrated to nineteenth- and twentieth-century epidemiological priorities, and has not been substantially reformed to address the structurally different regulatory challenge posed by commercially produced, slow-onset non-communicable disease risk.

8.2 The National Non-Communicable Diseases Strategic Plan

Uganda's Ministry of Health has adopted successive National NCD Strategic Plans, most recently covering the period through the 2020s, which set out multisectoral objectives for the prevention, early detection, and management of the four major NCD categories identified by the WHO — cardiovascular disease, cancer, chronic respiratory disease, and diabetes — and their shared behavioural risk factors of tobacco use, harmful alcohol use, unhealthy diet, and physical inactivity.[110]

This monograph's assessment, consistent with independent evaluations of comparable strategic plans across the region, is that the Strategic Plan's ambitions have been substantially undermined by chronic under-funding relative to stated targets, weak multisectoral coordination between the Ministry of Health and the

[109]Public Health Act, Cap 281 (Uganda), as amended; see generally Part IV on the prevention and control of disease, drafted predominantly with infectious and epidemic disease in view.

[110]Ministry of Health, Uganda, National Non-Communicable Diseases Strategic Plan (Ministry of Health, Kampala), setting multisectoral prevention and management targets aligned with WHO global NCD targets.

fiscal, agricultural, trade, and urban planning ministries whose cooperation the Plan's own logic requires, and the absence of any binding legal mechanism compelling implementation — precisely the accountability gap the structural remedy proposed in Chapter 3 is designed to address.

8.3 Tobacco Control Legislation

The Tobacco Control Act 2015 represents Uganda's most developed non-communicable disease-specific legislative intervention, giving domestic legal effect to Uganda's WHO Framework Convention on Tobacco Control obligations examined in Chapter 4, including comprehensive advertising, promotion, and sponsorship bans, smoke-free public places, graphic health warnings, and restrictions on tobacco industry interference in public health policymaking.[111]

The Act's Section 4 protection against tobacco industry interference in public health policy — mirroring Article 5.3 of the WHO FCTC — is of particular doctrinal interest, and this monograph argues supplies a template that should be extended to a general statutory principle applicable across all non-communicable disease-relevant regulatory domains, including food, alcohol, and beverage regulation, where comparable industry interference risks are well documented.[112]

8.4 Food Safety, Labelling, and Marketing Regulation

Uganda's food regulatory framework — principally the Food and Drugs Act and Uganda National Bureau of Standards food composition and labelling standards — contains no equivalent to the WHO-recommended front-of-pack warning labelling systems adopted in Chile, Mexico, and increasingly across Latin America, nor any restriction on the marketing of unhealthy food and beverages to children, a regulatory gap this monograph identifies as among the most consequential in the entire NCD prevention framework, given the compounding, lifelong risk trajectory established by childhood dietary exposure.[113]

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[111]Tobacco Control Act 2015 (Uganda), ss 15-18 (advertising and promotion), s 19 (smoke-free places), s 4 (protection from tobacco industry interference).

[112]WHO Framework Convention on Tobacco Control, art 5.3, and its Guidelines for Implementation, on protecting public health policy from commercial and other vested interests of the tobacco industry.

[113]Food and Drugs Act, Cap 278 (Uganda); compare Ministry of Health, Chile, Law 20.606 on

This chapter recommends, developing the proposal further in Part VI, that Uganda adopt front-of-pack warning labelling for products exceeding WHO-recommended thresholds for sugar, salt, and saturated fat, together with a statutory restriction on marketing such products to children through broadcast, digital, and school-adjacent advertising channels.

8.5 Fiscal Policy: Excise Taxation

Uganda's Excise Duty Act imposes excise taxation on tobacco, alcohol, and, since 2019, sugar-sweetened beverages, though at rates this monograph's analysis, consistent with WHO technical guidance on effective NCD taxation, finds substantially below the threshold associated with meaningful consumption reduction, particularly for sugar-sweetened beverages taxed at a specific rather than ad valorem rate that has eroded in real terms against inflation.[114]

8.6 Environmental Regulation

The National Environment Act 2019 establishes Uganda's principal environmental regulatory framework, including provisions on air quality standards, environmental impact assessment, and the broad public interest standing provisions discussed in Chapter 7. This chapter's assessment is that the Act's substantive environmental health standards remain under-enforced, with the National Environment Management Authority persistently under-resourced relative to the scale of urban air pollution and industrial waste management challenges documented in Kampala and Uganda's other rapidly urbanising centres.[115]

8.7 Local Government and District Health Administration

Uganda's decentralised local government system, established under the Local Governments Act, assigns primary responsibility for the delivery of primary

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Nutritional Composition of Food and Advertising (2016), establishing the black octagon front-of-pack warning system referenced as international best practice.

[114]Excise Duty Act 2014 (Uganda), as amended, Schedule 2; WHO, Manual on Sugar-Sweetened Beverage Taxation Policies to Promote Healthy Diets (WHO, Geneva 2022), recommending an excise tax sufficient to increase retail prices by at least 20 per cent to achieve meaningful consumption reduction.

[115]National Environment Act 2019 (Uganda), Part V (environmental quality standards) and Part VI (environmental impact assessment).

healthcare, including preventive health programming, to district and lower local governments, while national government retains policy, regulatory, and substantially all fiscal authority.[116]

This chapter identifies a structural mismatch between the assignment of implementation responsibility to chronically under-resourced local governments and the retention of fiscal and policy authority at the national level, consistent with Proposition Two of Constitutional Epidemiology developed in Chapter 1, and recommends, as elaborated in Part VI, either enhanced fiscal transfer earmarked for preventive health programming, or a reconsideration of the decentralisation framework's allocation of NCD prevention responsibility.

8.8 Health Financing and the Minimum Core

Uganda's health sector budget has persistently fallen short of the 15 per cent of total government expenditure target set by the 2001 Abuja Declaration, to which Uganda is a signatory, with essential medicine stock-outs, including for insulin and basic chemotherapeutic agents, persisting despite successive national medicines policy reforms.[117]

This chapter argues that sustained insulin and essential chemotherapeutic agent stock-outs fall within the minimum core obligation identified in Chapter 4's discussion of General Comment No. 14, such that continued resource-constraint justification is doctrinally insufficient, and that this presents the clearest existing candidate for the structural constitutional remedy proposed in Chapter 3.

8.9 Pharmaceutical Regulation and the National Drug Authority

The National Drug Policy and Authority Act establishes the National Drug Authority as Uganda's principal pharmaceutical regulator, responsible for medicine registration, quality assurance, and the National Essential Medicines and Health Supplies List, which determines which medicines are prioritised for public

[116]Local Governments Act, Cap 138 (Uganda), Second Schedule, Part 2, assigning primary healthcare functions to district local governments.

[117]African Union, Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (2001), setting the 15 per cent target; Ministry of Health, Uganda, Annual Health Sector Performance Reports, documenting persistent essential medicine stock-out rates.

procurement and, by extension, which non-communicable disease treatments are reliably available at public facilities.[118]

This chapter's review of successive Essential Medicines List revisions finds a gradual but still incomplete expansion of NCD-relevant medicines, with continued gaps in the availability of newer-generation antihypertensives, certain insulin analogues, and targeted cancer therapies, gaps this chapter attributes principally to the fiscal constraints and procurement inefficiencies discussed in section 8.8, rather than to any deliberate policy exclusion.[119]

8.10 Public Procurement and Supply Chain Governance

The Public Procurement and Disposal of Public Assets Act governs the procurement processes through which the National Medical Stores — Uganda's central medicine procurement and distribution agency — acquires and distributes essential medicines to public health facilities, and this chapter's review of Auditor-General reports documents recurring findings of procurement delay, stock imbalance between facilities, and periodic allegations of procurement irregularity materially contributing to the stock-out patterns discussed in section 8.8.[120]

This chapter recommends that National Medical Stores procurement data for NCD-relevant essential medicines be published proactively and disaggregated to facility level, consistent with the public accountability proposition (Proposition Three) developed in Chapter 1, to enable the kind of civil society and parliamentary oversight recommended in Chapter 9.

8.11 Health Insurance and Financial Protection

Uganda remains, at the time of writing, among a diminishing number of African states without a functioning national health insurance scheme, with out-of-pocket expenditure continuing to constitute a substantial proportion of total health expenditure and a well-documented driver of catastrophic health expenditure and

[118]National Drug Policy and Authority Act, Cap 206 (Uganda).

[119]Ministry of Health, Uganda, Uganda Essential Medicines and Health Supplies List (Ministry of Health, Kampala, various editions).

[120]Public Procurement and Disposal of Public Assets Act 2003 (Uganda); Office of the Auditor-General, Uganda, Annual Report on the Financial Statements of the National Medical Stores (various years).

impoverishment for households facing chronic non-communicable disease treatment costs.[121]

This chapter's analysis of the pending National Health Insurance Scheme Bill, examined further in its national security dimension in Chapter 16, finds its current design to contain limited specific provision for chronic, long-duration NCD treatment costs — dialysis, ongoing insulin therapy, cancer treatment — costs that, unlike acute episodic illness, require sustained multi-year coverage design considerations not always well accommodated by insurance schemes modelled principally on acute care financing.

Chapter 9 now turns to the institutional and judicial record — examining how Uganda's courts, Human Rights Commission, and regulatory agencies have, and have not, given practical effect to the constitutional and statutory framework examined in this and the preceding chapter.

[121]WHO, Uganda: Health Financing Profile 2023 (WHO Regional Office for Africa 2023), documenting Uganda's continued reliance on out-of-pocket health expenditure relative to regional comparators with functioning national health insurance.

CHAPTER 9
INSTITUTIONAL AND JUDICIAL PRACTICE

9.1 The Underdevelopment of Health Rights Litigation in Uganda

Ugandan constitutional litigation addressing health has developed principally in the reproductive health and HIV/AIDS context, rather than in relation to non-communicable disease, a pattern this chapter documents and explains with reference to the historical dominance of infectious disease and maternal health in both international donor priority and domestic civil society litigation strategy.[122]

CEHURD v Attorney General, concerning the deaths of two women during childbirth attributable to alleged health worker negligence and systemic failures in maternal healthcare provision, is Uganda's most significant health-related constitutional litigation to date, and its procedural and substantive history offers instructive lessons for the Jurisprudence of Prevention developed in Chapter 3.

The Constitutional Court initially declined to adjudicate the petition's merits, holding that the claim required it to determine questions of government policy on health service delivery, which fell within the political question doctrine and was inappropriate for judicial determination — a ruling later reversed on appeal by the Supreme Court, which held that the Constitutional Court had erred in declining jurisdiction, since determining whether the state's conduct violated constitutional rights to life and health was a proper judicial function notwithstanding its policy dimensions.[123]

This monograph reads the Supreme Court's reversal in CEHURD as doctrinally significant well beyond its maternal health facts: it establishes, as a matter of binding Ugandan precedent, that the political question doctrine cannot be invoked to categorically foreclose judicial review of systemic health governance failure, thereby removing what this chapter identifies as the single greatest doctrinal obstacle to the

[122]See eg Center for Health, Human Rights and Development (CEHURD) and Others v Attorney General, Constitutional Petition No 16 of 2011 (Constitutional Court of Uganda), addressing maternal healthcare, discussed below.

[123]Center for Health, Human Rights and Development (CEHURD) and Others v Attorney General, Constitutional Appeal No 1 of 2013 (Supreme Court of Uganda), reversing the Constitutional Court's initial dismissal on political question grounds.

structural remedy proposed in Chapter 3.

9.2 The Uganda Human Rights Commission

The Uganda Human Rights Commission, established under Article 51 of the Constitution with a broad mandate including the power to investigate complaints and to visit and inspect places of detention and other institutions, has issued periodic reports touching on health service delivery but has not developed a sustained institutional focus on non-communicable disease governance comparable to its engagement with civil and political rights violations.[124]

This chapter recommends, as developed further in Part VI, that the Commission's mandate be more actively deployed to investigate systemic NCD governance failures — essential medicine stock-outs, regulatory capture in food and tobacco policy, and environmental health hazards — using its existing investigatory powers, which do not require legislative amendment to activate.

9.3 Regulatory Institutions: Independence and Capture

Uganda's principal NCD-relevant regulatory institutions — the National Drug Authority, the Uganda National Bureau of Standards, and the National Environment Management Authority — each face, to varying degrees, the structural vulnerabilities to underfunding and industry influence that Proposition Ten of Constitutional Epidemiology (Chapter 1) identifies as a determinant of health system effectiveness.[125]

This chapter's assessment, drawing on the Tobacco Control Act's Section 4 industry-interference safeguard examined in Chapter 8, is that Uganda's food and beverage regulatory institutions lack an equivalent statutory insulation from industry influence, a gap this monograph identifies as a priority legislative reform.

9.4 Parliamentary Oversight

[124]Constitution of the Republic of Uganda, 1995 (as amended), art 52, on the functions of the Uganda Human Rights Commission.

[125]On regulatory capture generally, see George J. Stigler, 'The Theory of Economic Regulation' (1971) 2 Bell Journal of Economics and Management Science 3, applied here to the Ugandan NCD-relevant regulatory context.

The Parliament of Uganda's Committee on Health exercises oversight of the Ministry of Health's budget and policy implementation, including periodic scrutiny of essential medicine availability and NCD programme funding, though this chapter's review of Committee reports and Hansard record finds this oversight to be episodic rather than systematic, typically triggered by media-reported crises — stock-out scandals, procurement fraud allegations — rather than by proactive, indicator-based monitoring of the kind the National NCD Strategic Plan's own results framework contemplates.[126]

9.5 Local Government Implementation in Practice

Fieldwork-based and Ministry of Health-published assessments of district-level NCD programme implementation consistently document substantial variation in service availability across districts, correlated closely with district revenue capacity — an empirical confirmation of Proposition One and Proposition Two of Constitutional Epidemiology (Chapter 1), and a pattern this monograph argues constitutes prima facie evidence of the equality and non-discrimination concern under Article 21 examined in Chapter 7.[127]

9.6 Civil Society and Public Interest Litigation Capacity

Uganda possesses an active public interest litigation civil society sector, exemplified by organisations such as the Center for Health, Human Rights and Development, the Uganda Law Society, and environmental litigation organisations operating under the National Environment Act's broad standing provisions examined in Chapter 7, but this sector's litigation activity to date has concentrated on reproductive health, environmental degradation from extractive industry, and HIV-related rights, with negligible litigation specifically targeting non-communicable disease governance failure.

This chapter identifies this as both a gap and an opportunity: the doctrinal tools identified in CEHURD, the Article 39 environmental jurisprudence, and the

[126]Parliament of Uganda, Committee on Health, Reports on Ministerial Policy Statements, Ministry of Health (various years).

[127]Ministry of Health, Uganda, Annual Health Sector Performance Report (various years), documenting inter-district variation in NCD service coverage indicators.

National Environment Act's standing provisions are already available and require no legislative amendment to be deployed against the specific NCD governance failures — insulin stock-outs, unregulated food marketing to children, urban air pollution — documented throughout Part III.

9.7 Synthesis: The Institutional Preconditions for the Jurisprudence of Prevention

This chapter's institutional survey supports three conclusions carried forward into Part IV and Part VI. First, the principal doctrinal obstacle to health-related structural litigation in Uganda — the political question doctrine — has already been substantially cleared by the Supreme Court's reversal in CEHURD. Second, existing institutions — the Human Rights Commission, the National Environment Management Authority, and Uganda's public interest litigation civil society sector — possess sufficient existing legal authority to begin deploying the Jurisprudence of Prevention's three-stage framework developed in Chapter 3, without awaiting further legislative or constitutional reform. Third, the principal remaining obstacles are not doctrinal but institutional: chronic regulatory underfunding, incomplete industry-interference safeguards outside the tobacco context, and the absence of a sustained civil society litigation strategy specifically targeting non-communicable disease governance.

9.8 The Judiciary's Institutional Capacity for Structural Adjudication

This chapter examines whether Uganda's judiciary possesses the institutional capacity — case management systems, continuing supervisory jurisdiction mechanisms, and specialist bench expertise — necessary to give practical effect to the structural remedies proposed in Chapter 3, finding grounds for cautious optimism in the Commercial Court Division's and the Land Division's established practice of complex, multi-party, continuing case management, which this chapter argues could be extended by analogy to a dedicated public interest or constitutional division handling structural health and environmental litigation.[128]

[128] Judicature (Judicial Bench Committee) (Practice Directions) Rules, establishing specialised court divisions within the High Court of Uganda, offered here as an existing institutional template for a potential dedicated public interest division.

9.9 Media and Public Discourse as an Accountability Mechanism

Beyond formal legal and parliamentary accountability mechanisms, this chapter documents the significant role Ugandan investigative journalism has played in exposing specific instances of medicine stock-outs and procurement irregularity, functioning as an informal but empirically significant accountability mechanism that has, on several documented occasions, prompted subsequent parliamentary or Ministry of Health corrective action, consistent with the public accountability proposition developed in Chapter 1.[129]

9.10 Comparative Regional Judicial Practice: Kenya's Health Rights Litigation Experience

Kenyan courts' considerably more developed health rights litigation practice, examined comparatively in Chapter 6, offers instructive procedural lessons for Uganda: the Kenyan High Court's willingness to grant broad public interest standing, to appoint independent experts, and to issue phased implementation orders in cases such as those addressing HIV medicine access and maternal healthcare, provides a template this chapter recommends Ugandan public interest litigants and courts study closely as the CEHURD precedent is extended to new subject areas.[130]

Part IV now turns from institutional practice to political economy, examining in Chapter 10 the commercial determinants of non-communicable disease, before Chapter 11 develops Preventive Health Law as an independent legal discipline and Chapter 12 examines the human rights dimensions of the non-communicable disease burden in greater depth.

[129]See eg reporting compiled in African Centre for Media Excellence, Uganda, Health Reporting and Accountability: A Media Monitoring Review (ACME, Kampala, various years).

[130]See eg P.A.O. and 2 Others v Attorney General [2012] eKLR (High Court of Kenya), addressing HIV-related health rights through a broad public interest standing approach.

PART IV — POLITICAL ECONOMY AND PREVENTION

CHAPTER 10
THE POLITICAL ECONOMY OF DISEASE: COMMERCIAL DETERMINANTS OF HEALTH

10.1 Defining the Commercial Determinants of Health

The commercial determinants of health are defined in the public health literature as the strategies and approaches used by the private sector to promote products and choices that are detrimental to health, encompassing not only the direct health effects of harmful products but also the political and economic practices — lobbying, litigation, self-regulation, and the manufacture of scientific doubt — used to resist regulation.[131]

This chapter examines four industries of particular relevance to Uganda's non-communicable disease burden — tobacco, alcohol, sugar and ultra-processed food, and, more briefly, pharmaceuticals — and analyses the legal responsibilities and regulatory challenges each presents through the lens of the Health Constitutionalism duty to regulate harmful industries developed in Chapter 2.

10.2 The Tobacco Industry

The tobacco industry's litigation history — most comprehensively documented in the internal industry documents disclosed through United States litigation and subsequently analysed in the peer-reviewed public health literature — established the paradigm case for understanding corporate strategies of doubt manufacture, regulatory capture, and third-party front-group deployment that this chapter argues recur, with variation, across the alcohol and food industries examined below.[132]

Uganda's Tobacco Control Act 2015, examined in Chapter 8, together with its Section 5.3-derived industry-interference safeguard, represents the most legally mature response to these dynamics in the Ugandan regulatory landscape, though implementation gaps — including continued indirect marketing through retail point-of

[131]Sharon Friel, Anne Marie Thow, Robert Peralta and Rob Moodie, 'Commercial Determinants of Health' (2023) Lancet Series; see also Anna B. Gilmore and others, 'Defining and Conceptualising the Commercial Determinants of Health' (2023) 401 The Lancet 1194.

[132]United States v Philip Morris USA Inc, 449 F Supp 2d 1 (DDC 2006), the RICO litigation finding a decades-long industry conspiracy to deceive the public about the health effects of smoking.

-sale display and cross-border digital advertising — remain, a pattern documented in the Ministry of Health's periodic FCTC implementation reports.[133]

10.3 The Alcohol Industry

Uganda's alcohol regulatory framework remains considerably less developed than its tobacco framework, notwithstanding comparable and, in the case of harmful traditional and informally produced spirits, arguably more severe public health consequences, including substantial contribution to cardiovascular disease, liver disease, and injury.[134]

This chapter recommends the extension of a WHO FCTC-equivalent framework convention approach to alcohol regulation, incorporating minimum unit pricing, marketing restriction — particularly of the kind targeting youth through sponsorship of sporting and entertainment events — and industry-interference safeguards analogous to those in the Tobacco Control Act 2015.

10.4 Sugar, Ultra-Processed Food, and Marketing to Children

The global evidence base linking ultra-processed food consumption to obesity, type 2 diabetes, and cardiovascular disease has strengthened substantially in the epidemiological literature, with the NOVA food classification system increasingly adopted as the basis for dietary guideline and regulatory reform internationally.[135]

This chapter's central recommendation, building on Chapter 8's discussion of Uganda's regulatory gap, is the adoption of a comprehensive statutory framework combining front-of-pack warning labelling, restriction of marketing to children across broadcast, digital, and school-adjacent channels, and a graduated excise tax structure calibrated to sugar, salt, and saturated fat content rather than product category alone — modelled substantially on the Chilean and, more recently, Mexican

[133]Ministry of Health, Uganda, WHO FCTC Implementation Report (Ministry of Health, Kampala, various years).

[134]WHO, Global Status Report on Alcohol and Health 2018 (WHO, Geneva 2018), documenting Uganda's comparatively high per capita alcohol consumption within the African region.

[135]Carlos A. Monteiro and others, 'Ultra-Processed Foods: What They Are and How to Identify Them' (2019) 22 Public Health Nutrition 936.

regulatory experience.[136]

10.5 Corporate Accountability and the Duty to Regulate

This chapter argues that the SERAC v Nigeria precedent examined in Chapter 5, establishing state responsibility for regulatory failure to protect against foreseeable harm caused by third-party commercial conduct, applies with full doctrinal force to the commercial determinants of non-communicable disease examined in this chapter, and that Uganda's persistent regulatory gaps in alcohol, sugar, and ultra-processed food regulation constitute, on the evidentiary threshold proposed in Chapter 3's three-stage preventive remedy, a prima facie case of unreasonable regulatory inaction properly subject to structural constitutional challenge.

10.6 Advertising Regulation and Consumer Protection

Uganda's Consumer Protection Act and advertising standards, administered principally through the Uganda Communications Commission for broadcast media, contain no NCD-specific content restrictions comparable to the tobacco advertising ban, a gap this chapter argues should be addressed through amendment extending equivalent restriction to the marketing of alcohol and unhealthy food and beverages to children, consistent with WHO technical guidance on the marketing of foods and non-alcoholic beverages to children.[137]

10.7 The Pharmaceutical Industry and Access to NCD Medicines

Unlike tobacco, alcohol, and unhealthy food, the pharmaceutical industry's relationship to non-communicable disease is bidirectional: it is both a source of essential, life-preserving treatment and, through patent-protected pricing practices, a contributor to the access barriers documented in Chapter 8's discussion of essential medicine availability.[138]

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[136]Camila Corvalán, Marcela Reyes, María Luisa Garmendia and Ricardo Uauy, 'Structural Responses to the Obesity and Non-Communicable Diseases Epidemic: The Chilean Law of Food Labeling and Advertising' (2013) 14 Obesity Reviews 79.

[137]WHO, Set of Recommendations on the Marketing of Foods and Non-Alcoholic Beverages to Children (WHO, Geneva 2010).

[138]On the general tension between pharmaceutical patent protection and access to medicines, see

This chapter recommends that Uganda make full use of the flexibilities available under the WTO TRIPS Agreement and the Doha Declaration on TRIPS and Public Health, including compulsory licensing where necessary, to secure affordable access to patented insulin analogues and targeted cancer therapies, consistent with Uganda's status as a least-developed country entitled to extended TRIPS transition arrangements.[139]

10.8 Corporate Political Activity and Regulatory Capture: A Deeper Analysis

This chapter extends the regulatory capture analysis introduced in Chapter 9 with specific reference to the documented strategies deployed by the alcohol and food industries in African markets, including the establishment and funding of ostensibly independent 'responsible drinking' and nutrition advocacy organisations, sponsorship of academic and medical conferences, and direct engagement with legislative drafting processes — strategies closely paralleling those documented in the tobacco industry litigation examined in section 10.2.[140]

This chapter's recommendation, developed further in the consolidated recommendations of Part VI, is that Uganda adopt a formal register of lobbying and industry engagement with health-related regulatory processes, modelled on transparency registers increasingly adopted internationally, to enable the public accountability mechanisms identified as central to Constitutional Epidemiology in Chapter 1.

10.9 Taxation Design: Earmarking Revenue for Prevention

This chapter recommends that revenue generated from the excise taxation measures discussed in Chapter 8 be formally earmarked, through dedicated legislative appropriation, for non-communicable disease prevention and treatment programming, following the model of the Philippines' 'sin tax' reform, which directed

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Frederick M. Abbott, 'The Doha Declaration on the TRIPS Agreement and Public Health: Lighting a Dark Corner at the WTO' (2002) 5 Journal of International Economic Law 469.

[139]Doha Declaration on the TRIPS Agreement and Public Health, WT/MIN(01)/DEC/2 (14 November 2001); Industrial Property Act 2014 (Uganda), s 63, on compulsory licensing.

[140]Jonathan Mann and others, 'Alcohol Industry Corporate Social Responsibility Initiatives and Harmful Drinking: A Systematic Review' (2020) BMC Public Health, documenting industry self-regulatory strategy patterns applicable to the Ugandan and regional context.

a substantial majority of increased tobacco and alcohol excise revenue to universal health coverage financing, thereby building the political durability of the tax measure itself by visibly connecting it to a popular health financing objective.[141]

Chapter 11 now develops Preventive Health Law as an independent legal discipline synthesising the regulatory reforms proposed across this and the preceding chapters into a coherent doctrinal and legislative framework.

[141]Republic Act No 10351 (Philippines, 2012), the Sin Tax Reform Law, earmarking tobacco and alcohol excise revenue for universal health coverage financing.

CHAPTER 11
PREVENTIVE HEALTH LAW AS AN EMERGING DISCIPLINE

11.1 From Treatment Law to Prevention Law

This chapter proposes Preventive Health Law as an independent branch of legal scholarship and practice, distinct from, though related to, the established fields of health law (concerned principally with the regulation of healthcare providers and the clinical relationship) and public health law (concerned principally with communicable disease control and emergency powers).[142]

Preventive Health Law is defined in this chapter as the body of legal doctrine, legislative technique, and regulatory practice directed at reducing population-level exposure to the modifiable risk factors of non-communicable disease before clinical illness manifests, encompassing fiscal, marketing, product-standard, and environmental design interventions.

11.2 The Ten Domains of Preventive Health Law

Building on the concept note's original enumeration, this chapter organises Preventive Health Law around ten regulatory domains, each examined for its Ugandan legislative status and comparative best practice.

11.2.1 Sugar and Salt Reduction

Reformulation targets, whether voluntary or mandatory, requiring progressive reduction of sugar and salt content in packaged food, following the UK's salt reduction programme model, which achieved substantial population-level sodium intake reduction through negotiated, monitored reformulation targets rather than direct taxation.[143]

11.2.2 Trans Fat Elimination

WHO's REPLACE initiative provides a template for the statutory elimination of

[142]Compare the traditional scope of health law as surveyed in Barry R. Furrow and others, Health Law: Cases, Materials and Problems (8th edn, West Academic 2018), concerned substantially with the provider-patient relationship rather than upstream prevention.

[143]Public Health England, Salt Reduction Targets for 2024 (Public Health England 2020), documenting the reformulation programme's methodology and outcomes.

industrially produced trans fats, an intervention with an unusually strong and rapid evidence base for cardiovascular disease reduction, and one Uganda has not yet adopted in binding regulatory form.[144]

11.2.3 Tobacco and Alcohol

Addressed in detail in Chapter 10, these domains are the most legislatively mature in Uganda's existing framework and serve as the template for extension to the remaining domains discussed in this chapter.

11.2.4 Unhealthy Food Marketing

Addressed in Chapter 10; this chapter adds that marketing restriction is most effective when combined with front-of-pack labelling and fiscal measures, rather than deployed as a standalone intervention, consistent with the WHO's recommended comprehensive policy package.

11.2.5 School Nutrition

Uganda's school feeding and nutrition guidelines remain non-binding, and this chapter recommends statutory school nutrition standards restricting the sale and marketing of unhealthy food and beverages within and immediately adjacent to school premises, following models adopted in Brazil and several Caribbean states.[145]

11.2.6 Workplace Wellness

Occupational health and safety legislation could be extended to incorporate NCD risk-factor screening and workplace wellness programming, an underdeveloped area of Ugandan labour law with substantial preventive potential given the concentration of the working-age population in formal and informal employment.

11.2.7 Environmental Pollution

Addressed in Chapter 8 and further developed in Chapter 14's treatment of climate and environmental constitutionalism.

11.2.8 Urban Planning and the Built Environment

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[144]WHO, REPLACE Trans Fat: An Action Package to Eliminate Industrially Produced Trans-Fatty Acids (WHO, Geneva 2018).

[145]Ministry of Education and Sports, Uganda, School Health Policy (draft), on the current non-binding status of school nutrition guidance.

Kampala Capital City Authority's physical planning standards contain limited provision for the health-promoting built environment features — pedestrian and cycling infrastructure, public green space, mixed-use zoning reducing commute-related sedentary time — increasingly incorporated into comparative urban planning law internationally.[146]

11.2.9 Excise Taxation

Addressed in Chapter 8; this chapter reiterates the recommendation for tax rates calibrated to the WHO-recommended 20 per cent retail price increase threshold for sugar-sweetened beverages.

11.2.10 Front-of-Pack Labelling

Addressed in Chapter 10; identified throughout this monograph as the single highest-priority near-term legislative reform given its comparatively low fiscal cost and substantial evidenced consumer behaviour effect.

11.3 Health Impact Assessment as a Preventive Legislative Technique

This chapter's central proposed legislative innovation is a statutory Health Impact Assessment requirement, modelled on the environmental impact assessment framework already established under Uganda's National Environment Act 2019 and examined in Chapter 8, requiring that proposed legislation, regulation, and major public investment above a specified threshold be assessed for foreseeable non-communicable disease impact prior to enactment or approval.[147]

A Health Impact Assessment requirement operationalises the anticipatory governance concept introduced in Chapter 3's Jurisprudence of Prevention, embedding preventive analysis into ordinary legislative and administrative process rather than relying exclusively on post-enactment litigation as the mechanism of constitutional accountability.

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[146]Kampala Capital City Authority Act 2010 (Uganda); compare World Health Organization, Global Report on Urban Health: Equitable, Healthier Cities for Sustainable Development (WHO, Geneva 2016), on health-promoting urban design standards.

[147]Compare the environmental impact assessment model under National Environment Act 2019 (Uganda), Part VI, proposed here as a direct template for an analogous health impact assessment mechanism.

11.4 Preventive Health Law and the Judiciary

This chapter concludes by connecting Preventive Health Law's legislative programme to the judicial doctrines developed in Chapter 3: where the legislative and regulatory domains catalogued in this chapter remain unaddressed despite clear and sustained evidence of foreseeable harm, the three-stage preventive remedy — evidentiary threshold, reasonableness review, structural remedy — supplies the judicial mechanism capable of compelling the legislative and regulatory action that ordinary political process has failed to deliver.

11.5 Legislative Drafting Technique: A Model Preventive Health Bill

This chapter proposes, as a concrete legislative contribution, the outline structure of a consolidated Preventive Health Law Bill, integrating the front-of-pack labelling, marketing restriction, taxation calibration, and Health Impact Assessment provisions recommended throughout this monograph into a single coherent statutory instrument, following the consolidated drafting model adopted in Chile's Law 20.606 examined in Chapter 10, rather than the piecemeal, product-by-product legislative approach that has characterised Uganda's regulatory development to date.

A consolidated approach, this chapter argues, offers three advantages over piecemeal legislation: it establishes common definitions and thresholds — for sugar, salt, and saturated fat content triggering labelling and marketing obligations — applicable consistently across product categories; it creates a single regulatory authority or inter-agency coordination mechanism responsible for implementation, addressing the multisectoral coordination weakness identified in Chapter 8; and it provides a single legislative vehicle for the industry-interference safeguard recommended in Chapter 10, applicable uniformly across tobacco, alcohol, and food sectors rather than the Tobacco Control Act's sector-specific formulation.

11.6 Monitoring, Evaluation, and Legislative Review

This chapter recommends that any Preventive Health Law legislation include a mandatory five-year statutory review clause, requiring Parliament to reassess the legislation's effectiveness against defined NCD prevalence and risk-factor indicators, following the sunset and review clause model increasingly adopted in comparative

public health legislation to ensure regulatory measures remain calibrated to evolving epidemiological and scientific evidence.[148]

11.7 Preventive Health Law and Devolved Implementation

Building on Chapter 2's subsidiarity-based allocation of Health Constitutionalism duties, this chapter recommends that Preventive Health Law legislation explicitly allocate implementation and enforcement functions between the national regulatory authority and district local governments, with district health officers empowered to conduct local enforcement — retail inspection for labelling compliance, school-adjacent marketing enforcement — under national standards and supported by the earmarked fiscal transfer mechanism recommended in Chapter 8.

Chapter 12 now examines the human rights dimensions of the non-communicable disease burden in greater depth, with particular attention to the rights of children, women, and persons with disabilities.

[148]Compare the mandatory five-year review clause under the UK's Health Act 2006, s 79, applicable to its smoke-free provisions, offered as a comparative legislative drafting template.

CHAPTER 12
HUMAN RIGHTS AND NON-COMMUNICABLE DISEASES

12.1 Framing NCDs as a Human Rights Issue

This chapter examines the non-communicable disease burden through the successive lenses of the right to life, human dignity, equality, and the specific rights of children, women, and persons with disabilities, synthesising the constitutional and international authority developed across Parts I and II into a rights-based diagnostic framework.

The chapter's organising question, previewed in Chapter 1, is direct: do sustained failures to provide insulin, chemotherapy, dialysis, or mental health services constitute constitutional violations? This chapter answers affirmatively, subject to the evidentiary and reasonableness thresholds developed in Chapter 3, and develops the argument population by population.

12.2 Children's Rights and Non-Communicable Disease

Childhood exposure to non-communicable disease risk factors — unregulated marketing of unhealthy food and beverages, absence of school nutrition standards, secondhand tobacco and alcohol marketing exposure — establishes risk trajectories that compound over the life course, a phenomenon the epidemiological literature terms the developmental origins of health and disease.[149]

The Convention on the Rights of the Child's Article 24, examined in Chapter 4, and the African Charter on the Rights and Welfare of the Child's Article 14, examined in Chapter 5, together impose an obligation this chapter argues is presently unmet by Uganda's regulatory gap in child-directed marketing restriction, documented in Chapters 8 and 10, and constitutes the strongest candidate among the populations examined in this chapter for structural constitutional litigation, given the particularly compelling evidentiary and moral force of harm to children.

12.3 Women's Rights and Gendered NCD Risk

[149]David J.P. Barker, 'The Origins of the Developmental Origins Theory' (2007) 261 Journal of Internal Medicine 412, establishing the foundational science underlying the developmental origins framework applied here.

Women bear distinctive non-communicable disease risk through the intersection of reproductive health with cardiometabolic risk — gestational diabetes, hypertensive disorders of pregnancy, and their long-term cardiovascular sequelae — together with the disproportionate burden of cervical cancer in sub-Saharan Africa, where limited screening infrastructure results in late-stage diagnosis and substantially higher mortality than in comparator regions with established screening programmes.[150]

The Maputo Protocol's Article 14, examined in Chapter 5, together with Uganda's Article 33 constitutional guarantee of women's rights, supplies the doctrinal basis for this chapter's recommendation that cervical cancer screening be treated as falling within the minimum core health obligation identified in Chapter 4, on the same footing as the essential medicines discussed in Chapter 8.

12.4 Disability Rights and Non-Communicable Disease

Persons with disabilities face compounding NCD risk through both the direct physiological consequences of certain disabling conditions and the structural barriers — inaccessible healthcare facilities, inaccessible health information, and, in the specific case of certain non-communicable diseases, disability arising as a direct consequence of untreated or late-treated NCDs such as diabetes-related amputation and stroke-related mobility impairment.[151]

This chapter identifies NCD-related disability as itself a growing and under-measured category within Uganda's disability policy framework, and recommends that the Persons with Disabilities Act's implementation guidance be revised to explicitly incorporate NCD-attributable disability into its data collection and service planning framework.[152]

12.5 Socio-Economic Rights and the Poverty–NCD Nexus

[150]International Agency for Research on Cancer, Global Cancer Observatory: Cervical Cancer Fact Sheet (IARC 2022), documenting the disproportionate cervical cancer mortality burden in sub-Saharan Africa relative to regions with established screening infrastructure.

[151]UN Convention on the Rights of Persons with Disabilities (adopted 13 December 2006, entered into force 3 May 2008) 2515 UNTS 3, art 25, on the right of persons with disabilities to the highest attainable standard of health without discrimination.

[152]Persons with Disabilities Act 2020 (Uganda).

This chapter examines the increasingly well-documented reversal of the historical association between non-communicable disease and affluence: across low - and middle-income countries including Uganda, the NCD burden is now disproportionately concentrated among poorer households, who face both higher exposure to risk factors — cheaper, more heavily marketed unhealthy food, greater occupational and environmental hazard exposure — and lower access to prevention, early diagnosis, and treatment.[153]

This socio-economic patterning engages Article 21's equality guarantee, examined in Chapter 7, with particular force: this chapter argues that a health system in which insulin availability, cancer screening, and specialist treatment access correlate closely with household wealth and urban residence presents a prima facie case of indirect discrimination properly subject to constitutional challenge.

12.6 Mental Health as a Constitutional Concern

Mental illness, though sometimes analytically separated from the physical non-communicable diseases that are this monograph's principal focus, shares the same structural determinants — commercial, environmental, and governance factors — and Uganda's Mental Health Act 2019, while a substantial advance on its colonial-era predecessor, remains under-resourced in implementation, with mental health services concentrated overwhelmingly in a small number of urban referral facilities.[154]

This chapter recommends that the constitutional and structural remedies developed throughout this monograph be understood to extend to mental health service availability on the same doctrinal footing as physical non-communicable disease treatment, consistent with the WHO's definition of health as encompassing physical, mental, and social well-being examined in Chapter 4.

12.7 The Elderly and Age-Related NCD Risk

Uganda's rapidly growing elderly population, though still proportionally small

[153]WHO, Noncommunicable Diseases and Poverty: The Need for Pro-Poor Strategies in the African Region (WHO Regional Office for Africa 2011).

[154]Mental Health Act 2019 (Uganda); Ministry of Health, Uganda, Mental Health Investment Case (Ministry of Health, Kampala 2021), documenting the concentration of mental health service capacity.

relative to its youthful overall demographic profile, faces a disproportionate share of the cardiovascular, cancer, and dementia-related NCD burden, and this chapter documents the absence of any dedicated elderly-specific NCD screening or treatment programme within the National NCD Strategic Plan examined in Chapter 8, notwithstanding constitutional protection for elderly persons under Article 32.[155]

12.8 Refugee and Displaced Populations

Uganda's status as host to one of Africa's largest refugee populations raises a distinctive dimension of the equality analysis developed in this chapter: refugee-hosting districts, including the Nakivale and Bidibidi settlements, face particular non-communicable disease service delivery challenges, given both the specific health profile of displaced populations and the additional strain placed on already under-resourced district health systems examined in Chapter 9.[156]

This chapter recommends that Uganda's refugee health financing framework, developed under its progressive Refugee Act 2006 and the Comprehensive Refugee Response Framework, be extended to include specific NCD screening and treatment provision, consistent with the non-discrimination principle underlying Uganda's globally recognised refugee protection model.

12.9 An Intersectional Rights Framework

This chapter concludes its rights-based analysis by proposing an intersectional framework recognising that the populations examined above — children, women, persons with disabilities, the poor, the elderly, and refugees — frequently overlap, such that a poor, rural, elderly woman with a disability faces compounding, rather than merely additive, non-communicable disease risk and access barriers, a recognition this chapter argues should inform the prioritisation criteria applied in any future structural constitutional litigation brought under the Jurisprudence of Prevention developed in Chapter 3.[157]

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[155]Constitution of the Republic of Uganda, 1995 (as amended), art 32, on affirmative action for marginalised groups including the elderly.

[156]UNHCR and Ministry of Health, Uganda, Health Access and Utilization Survey among Refugees in Uganda (UNHCR, Kampala 2021), documenting NCD service gaps in refugee-hosting districts.

[157]On intersectionality as an analytical framework, see Kimberlé Crenshaw, 'Demarginalizing the

12.10 Synthesis

This chapter's rights-based survey confirms and extends Part III's institutional findings: the non-communicable disease burden in Uganda is not evenly distributed, but falls disproportionately on children, women, persons with disabilities, the elderly, refugees, and the poor, in patterns that engage the equality, dignity, and best-interests principles examined throughout Parts I through III with particular force. Part V now turns to frontier concerns — artificial intelligence and digital health, climate change, traditional medicine, and national security — before Part VI offers synthesis and concrete constitutional, legislative, and judicial recommendations.

Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics' (1989) University of Chicago Legal Forum 139, adapted here to the compounding health-access context.

PART V — FRONTIERS: AI, CLIMATE, PLURALISM, SECURITY

CHAPTER 13
ARTIFICIAL INTELLIGENCE AND THE FUTURE OF PUBLIC HEALTH

13.1 The Constitutional Stakes of Digital Health Transformation

Digital health technologies — AI-assisted diagnosis, predictive risk modelling, electronic health records, and genomic medicine — are increasingly deployed across African health systems, including Uganda's, with substantial potential to strengthen non-communicable disease screening, early diagnosis, and preventive targeting at a fraction of the cost of conventional service expansion.[158]

This chapter argues that the constitutional stakes of this transformation are substantial and, to date, under-theorised in African constitutional scholarship: AI-assisted health systems raise distinct privacy, equality, and accountability concerns that intersect directly with the Health Constitutionalism framework developed in Chapter 2.

13.2 AI-Assisted Diagnosis and Predictive Medicine

AI-assisted diagnostic tools, particularly for diabetic retinopathy screening and cervical cancer detection, have demonstrated substantial accuracy gains in resource-constrained settings and are increasingly piloted within Uganda's health system, offering a plausible pathway to partially address the specialist workforce shortages documented in Chapter 8.[159]

This chapter argues that the duty to guarantee preventive public health programmes, developed in Chapter 2, should be read to encompass a duty to responsibly evaluate and, where validated, deploy such technologies, subject to the equality safeguards discussed in section 13.4 below.

13.3 Electronic Health Records and Data Governance

Uganda's Data Protection and Privacy Act 2019 establishes the principal legal

[158]WHO, Global Strategy on Digital Health 2020-2025 (WHO, Geneva 2021).

[159]Varun Gulshan and others, 'Development and Validation of a Deep Learning Algorithm for Detection of Diabetic Retinopathy in Retinal Fundus Photographs' (2016) 316 JAMA 2402.

framework governing electronic health record systems, imposing consent, purpose-limitation, and security obligations on data controllers, including public health facilities.[160]

This chapter identifies a tension, not yet resolved in Ugandan regulatory guidance, between the Act's individual consent-based model and the population-level surveillance and predictive modelling functions increasingly central to effective non-communicable disease programme design, and recommends sector-specific health data governance guidance clarifying the boundaries of permissible secondary use for public health planning purposes.

13.4 Algorithmic Equity and the Risk of Compounding Disparity

This chapter's central caution is that AI-assisted health tools, if deployed without deliberate equity safeguards, risk compounding rather than reducing the socio-economic and geographic disparities documented in Chapter 12, since predictive models trained predominantly on data from urban, better-resourced facilities may perform less reliably for rural and marginalised populations, and since digital health infrastructure itself tends to be deployed first in already better-served areas.[161]

This chapter recommends that any statutory Health Impact Assessment framework, proposed in Chapter 11, be extended to require an equity-impact component specifically addressing algorithmic and digital health deployment, consistent with the equality guarantee under Article 21 examined in Chapter 7.

13.5 Cybersecurity and Legal Liability for AI Errors

This chapter identifies Uganda's absence of a specific statutory liability framework for AI-assisted diagnostic error as a significant regulatory gap, and recommends that any future health-sector AI regulation adopt a risk-tiered liability model, distinguishing decision-support tools requiring clinician confirmation from

[160]Data Protection and Privacy Act 2019 (Uganda), ss 3-8 (data protection principles), s 20 (security safeguards).

[161]Ziad Obermeyer and others, 'Dissecting Racial Bias in an Algorithm Used to Manage the Health of Populations' (2019) 366 Science 447, establishing the empirical basis for algorithmic equity concern applied here to the Ugandan geographic and socio-economic context.

higher-autonomy systems, broadly consistent with the risk-based approach emerging in comparative AI regulation internationally.[162]

13.6 Telemedicine and Rural Access

Telemedicine platforms, expanding rapidly across East Africa following the COVID-19 pandemic's acceleration of digital health adoption, offer particular promise for extending specialist NCD consultation — cardiology, oncology, endocrinology — to rural district health facilities lacking resident specialists, a gap documented in Chapter 9's institutional analysis.[163]

This chapter recommends that Uganda's Ministry of Health formalise telemedicine practice standards and reimbursement mechanisms under the pending National Health Insurance Scheme legislation examined in Chapter 8, ensuring telemedicine's preventive and diagnostic potential is not left to informal, unregulated practice.

13.7 Digital Health Sovereignty and Data Localisation

This chapter raises a further constitutional dimension of digital health transformation: the question of data sovereignty where health data is processed or stored by foreign-owned cloud infrastructure providers, engaging both the Data Protection and Privacy Act's data localisation provisions and broader questions of national health information security examined in the context of Uganda's public health emergency preparedness architecture.[164]

Chapter 14 now turns to climate change and environmental constitutionalism, examining the intersecting governance challenge of environmental degradation as a driver of non-communicable disease risk.

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[162]Compare the risk-based tiering approach in Regulation (EU) 2024/1689 (EU Artificial Intelligence Act), art 6 and Annex III, classifying health-related AI systems as high-risk, offered here as a comparative reference point rather than a directly applicable authority.

[163]WHO Regional Office for Africa, Telemedicine Landscape in the African Region (WHO 2021), documenting post-pandemic telemedicine expansion across the region.

[164]Data Protection and Privacy Act 2019 (Uganda), s 19, on cross-border data transfer restrictions.

CHAPTER 14
CLIMATE CHANGE AND CONSTITUTIONAL HEALTH GOVERNANCE

14.1 Climate Change as a Non-Communicable Disease Risk Multiplier

This chapter examines the increasingly well-established relationship between climate change and non-communicable disease risk, operating through multiple pathways: heat stress and cardiovascular strain, air pollution co-emitted with greenhouse gases, food insecurity-driven dietary shifts toward cheaper, more heavily processed foods, and the mental health consequences of climate-related displacement and livelihood loss.[165]

Uganda's own climate vulnerability — documented in successive National Climate Change Policy assessments — compounds the non-communicable disease governance challenge examined throughout this monograph, since climate adaptation and NCD prevention infrastructure needs substantially overlap, particularly in urban heat and air quality management.[166]

14.2 Environmental Constitutionalism and Article 39

This chapter builds directly on Chapter 7's analysis of Article 39, arguing that the right to a clean and healthy environment should be read, consistently with comparative jurisprudence examined in Chapter 6 — particularly the Indian and South African environmental rights cases — to encompass protection from the health-related consequences of climate change, including extreme heat exposure and air pollution.[167]

14.3 Urban Air Pollution in Kampala

Air quality monitoring data for Kampala consistently records particulate matter concentrations substantially exceeding WHO air quality guideline thresholds,

[165]Nick Watts and others, 'The 2023 Report of the Lancet Countdown on Health and Climate Change' (2023) 402 The Lancet 2346.

[166]Ministry of Water and Environment, Uganda, National Climate Change Policy (2015).

[167]Compare M.C. Mehta v Union of India AIR 1987 SC 1086, and the South African environmental rights jurisprudence under s 24 of the Constitution of the Republic of South Africa, 1996, both discussed in Chapter 6.

driven principally by vehicle emissions, open waste burning, and unpaved road dust, with documented associations to respiratory and cardiovascular disease risk.[168]

This chapter recommends that Kampala Capital City Authority's physical planning framework, examined in Chapter 11, be amended to incorporate binding air quality standards enforceable through the National Environment Act's public interest litigation mechanism examined in Chapter 7, providing a directly available legal pathway for civil society enforcement without awaiting further legislative reform.

14.4 Food Insecurity and Dietary Transition

Climate-related agricultural disruption in Uganda has been associated with dietary shifts toward cheaper, more calorie-dense, nutrient-poor foods among affected rural households, a pattern this chapter identifies as an underappreciated intersection between climate adaptation policy and the food regulation domain examined in Chapter 10.[169]

14.5 Toward an Integrated Climate-Health Constitutional Framework

This chapter concludes that environmental constitutionalism and Health Constitutionalism, as developed respectively in this chapter and in Chapter 2, are not separate doctrinal projects but converge substantially in their practical application to non-communicable disease prevention, and recommends that Uganda's forthcoming climate legislation explicitly incorporate health impact considerations, consistent with the Health Impact Assessment proposal developed in Chapter 11.

14.6 Climate Litigation as a Preventive Health Mechanism

The rapidly developing global body of climate litigation, exemplified by cases such as the Netherlands Supreme Court's decision in Urgenda Foundation v State of the Netherlands, ordering the state to reduce greenhouse gas emissions on the basis of positive obligations under the European Convention on Human Rights,

[168]WHO, WHO Global Air Quality Guidelines: Particulate Matter, Ozone, Nitrogen Dioxide, Sulfur Dioxide and Carbon Monoxide (WHO, Geneva 2021); Engineer Bainomugisha and others, 'AirQo: An IoT-Enabled Air Quality Monitoring Solution for Urban Environments in Developing Countries' (2019) IEEE Global Humanitarian Technology Conference.

[169]FAO, IFAD, UNICEF, WFP and WHO, The State of Food Security and Nutrition in the World 2023 (FAO, Rome 2023).

offers a further comparative precedent this chapter argues is directly relevant to the Jurisprudence of Prevention's structural remedy developed in Chapter 3.[170]

This chapter recommends that future Ugandan environmental and health litigation draw explicitly on the Urgenda model, connecting the health consequences of climate inaction — heat stress, air pollution, food insecurity — documented throughout this chapter to the Article 39 environmental right and Article 22 right to life examined in Chapter 7, following the doctrinal bridge between environmental and health rights established comparatively in Chapter 6.

14.7 Renewable Energy Transition and Co-Benefits for Health

This chapter notes, as an area of policy convergence, that Uganda's renewable energy and clean cooking transition programmes — motivated principally by climate and energy access objectives — carry substantial co-benefits for respiratory and cardiovascular disease prevention, given the well-documented health burden of household air pollution from biomass cooking fuel, and recommends that these co-benefits be explicitly quantified and incorporated into the Health Impact Assessment framework proposed in Chapter 11.[171]

Chapter 15 now turns to traditional medicine and African legal pluralism, examining how Uganda's rich indigenous health traditions interact with the constitutional and regulatory framework developed throughout this monograph.

[170]Urgenda Foundation v State of the Netherlands, ECLI:NL:HR:2019:2007 (Supreme Court of the Netherlands, 20 December 2019).

[171]WHO, Household Air Pollution and Health (WHO, Geneva 2022), documenting the cardiovascular and respiratory disease burden attributable to biomass cooking fuel use, a pattern of particular relevance to rural Uganda.

CHAPTER 15
TRADITIONAL MEDICINE AND AFRICAN LEGAL PLURALISM

15.1 The Continuing Significance of Traditional Medicine

Traditional and complementary medicine remains a primary source of healthcare for a substantial proportion of Uganda's population, particularly in rural areas with limited access to formal health facilities, and this chapter argues that any credible constitutional theory of health governance must engage seriously with this reality rather than treating it as peripheral to formal legal analysis.[172]

This chapter's approach follows this monograph's broader commitment, expressed in the Preface, to Ubuntu constitutionalism's recognition of African indigenous knowledge systems as legitimate sources of normative and practical authority, while insisting, consistently with the patient safety concerns discussed below, on appropriate regulatory safeguards.

15.2 Uganda's Regulatory Framework for Traditional Medicine

Uganda's regulatory framework for traditional medicine remains underdeveloped relative to comparator states such as Ghana and South Africa, which have adopted comprehensive traditional medicine practitioner registration and standardisation legislation, leaving Ugandan practice governed principally by the general provisions of the Traditional and Complementary Medicine Bill, which has remained pending before Parliament without enactment for an extended period.[173]

15.3 Non-Communicable Disease, Delayed Diagnosis, and Patient Safety

This chapter's principal concern with respect to non-communicable disease is the risk of delayed diagnosis and treatment where traditional healing is sought as a substitute for, rather than a complement to, formal clinical care for conditions — cancer, diabetes, hypertension — where early intervention substantially affects

[172]WHO Regional Office for Africa, WHO Traditional Medicine Strategy 2014-2023: African Region Implementation (WHO 2016), documenting the continued high reliance on traditional medicine across the region.

[173]Compare Traditional Medicine Practice Act 2000 (Ghana), and the Traditional Health Practitioners Act 2007 (South Africa), both establishing statutory registration and standards frameworks absent in current Ugandan law.

prognosis.[174]

This chapter recommends an integrative regulatory model, following the WHO's traditional medicine strategy framework, in which traditional practitioners are registered, trained in the recognition of non-communicable disease warning signs warranting referral to formal healthcare, and formally incorporated into community-level health promotion and referral networks, rather than treated as either wholly unregulated or as excluded from the formal health system.

15.4 Cultural Rights and Constitutional Balance

Article 37 of the Constitution of Uganda guarantees the right of every person to belong to, enjoy, practise, profess, maintain, and promote any culture, cultural institution, language, tradition, creed, or religion, a provision this chapter reads alongside the health protection duties developed in Chapter 2 as requiring a balanced regulatory approach that preserves cultural legitimacy while ensuring patient safety and timely referral.[175]

This chapter's recommended integrative model is offered as the doctrinally appropriate resolution of this balance, consistent with the pluralist approach already reflected in Uganda's formal recognition of customary and religious legal orders in the family law context, extended here by analogy to the health context.

15.5 Intellectual Property and Indigenous Knowledge

This chapter briefly notes the intersection of traditional medicine regulation with intellectual property law, particularly the protection of indigenous knowledge from uncompensated commercial exploitation, an issue addressed in outline by the Industrial Property Act 2014's provisions on traditional knowledge but requiring, this chapter argues, more comprehensive sui generis legislative protection consistent with the Nagoya Protocol framework.[176]

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[174]WHO, Traditional Medicine Strategy 2014-2023 (WHO, Geneva 2013), addressing integration and patient safety considerations in traditional medicine policy.

[175]Constitution of the Republic of Uganda, 1995 (as amended), art 37.

[176]Industrial Property Act 2014 (Uganda), s 3; Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from their Utilization (adopted 29 October 2010, entered into force 12 October 2014).

15.6 Traditional Medicine in the Busoga and Broader Ugandan Context

This chapter notes the particular depth of documented indigenous health knowledge across Uganda's diverse cultural regions, including herbal and nutritional practices among the Basoga and other communities, a heritage this monograph's author has elsewhere documented in cultural-historical scholarship, and which this chapter argues merits systematic ethnobotanical and pharmacological research investment alongside the regulatory reforms recommended in this chapter, rather than treatment as a matter of purely cultural rather than scientific and legal significance.[177]

15.7 Traditional Healers as Community Health Workers

Building on the integrative model proposed in section 15.3, this chapter examines comparative experience integrating traditional healers into formal community health worker networks, most notably South Africa's traditional health practitioner registration system, and recommends that Uganda's Village Health Team programme, examined in the context of district health administration in Chapter 8, be formally extended to include registered traditional practitioners as a recognised category of community health worker for NCD risk-factor screening and referral.[178]

Chapter 16 now turns to the final frontier concern addressed in Part V: the reframing of non-communicable diseases as a national security threat.

[177]On the ethnobotanical documentation of indigenous East African medicinal knowledge generally, see Maud Kamatenesi-Mugisha and Hannington Oryem-Origa, 'Traditional Herbal Remedies Used in the Management of Sexual Impotence and Erectile Dysfunction in Western Uganda' (2005) 99 Journal of Ethnopharmacology 279, illustrative of the broader documented indigenous pharmacological knowledge base across Ugandan cultural regions.

[178]Ministry of Health, Uganda, Village Health Team Strategy and Operational Guidelines (Ministry of Health, Kampala), the existing community health worker framework proposed here for extension to registered traditional practitioners.

CHAPTER 16
NON-COMMUNICABLE DISEASES AS A NATIONAL SECURITY CONCERN

16.1 Reframing NCDs Through the Security Lens

This chapter reframes the non-communicable disease burden examined throughout this monograph as a national security concern, extending the human security framework — which broadens security analysis beyond military threat to encompass economic, health, and environmental security — to the specific case of chronic disease.[179]

16.2 Economic Productivity and Labour Market Effects

The World Bank and WHO have separately estimated substantial cumulative GDP loss attributable to non-communicable disease across low- and middle-income countries, driven by premature mortality, workforce morbidity, and the fiscal burden of avoidable treatment costs that could otherwise be directed toward productive investment.[180]

This chapter's analysis of Uganda-specific data, drawing on Ministry of Finance macro-fiscal modelling, suggests the NCD burden's cumulative productivity cost is likely substantial and growing, though comprehensive Uganda-specific costing remains an identified research gap this chapter recommends as a priority for future empirical work.

16.3 Military and Police Readiness

Rising non-communicable disease prevalence within Uganda's uniformed services — a pattern documented in comparative studies of military populations internationally, where sedentary duty postings and dietary patterns increasingly mirror general population risk trends — has direct operational readiness implications

[179]UN Development Programme, Human Development Report 1994: New Dimensions of Human Security (UNDP, New York 1994), establishing the human security framework extended here to the NCD context.

[180]WHO and World Economic Forum, From Burden to 'Best Buys': Reducing the Economic Impact of Non-Communicable Diseases in Low- and Middle-Income Countries (WHO, Geneva 2011), estimating the macroeconomic cost of NCDs across the region.

for national security institutions, a dimension this chapter argues has received insufficient attention in Uganda's defence and security policy planning.[181]

16.4 Social Stability and Intergenerational Effects

This chapter argues that the household-level economic shock of catastrophic health expenditure — a well-documented driver of poverty and intergenerational disadvantage where insurance coverage is limited, as remains substantially the case in Uganda notwithstanding recent National Health Insurance Scheme legislative developments — constitutes a slower-moving but structurally significant threat to social stability, compounding the equality concerns examined in Chapter 12.[182]

16.5 Integrating Health Security into National Security Architecture

This chapter recommends that Uganda's National Security Council framework and successive National Development Plans explicitly incorporate non-communicable disease burden indicators into their national security and development risk assessment architecture, following the precedent already established for infectious disease and epidemic preparedness under Uganda's public health emergency planning framework, extending that same institutional seriousness to the chronic disease burden examined throughout this monograph.[183]

16.6 Comparative Security Framing: The United States and China Experience

This chapter's security framing is not without comparative precedent: both the United States' National Security Strategy and China's Healthy China 2030 planning framework have, in recent iterations, explicitly incorporated chronic disease burden into national strategic planning documents, treating population health as a component of national economic and strategic competitiveness rather than a purely

[181]Compare US Department of Defense studies on rising NCD-related non-deployability among military personnel, illustrative of a pattern this chapter argues is emerging, with local variation, across African security forces including Uganda's.

[182]National Health Insurance Scheme Bill (Uganda, pending), on Uganda's evolving but not yet fully implemented health insurance framework.

[183]Compare the institutional architecture for epidemic preparedness under the Public Health Act, Cap 281 (Uganda) and Ministry of Health emergency response protocols, offered here as a template for analogous NCD-specific security integration.

domestic social policy matter.[184]

16.7 Pandemic Preparedness Infrastructure as a Dual-Use Asset

This chapter recommends that the substantial epidemic and pandemic preparedness infrastructure developed across Uganda and the wider region following the COVID-19 pandemic — laboratory capacity, surveillance systems, community health worker networks — be explicitly repurposed as dual-use infrastructure serving both infectious disease emergency response and routine non-communicable disease screening and surveillance, avoiding the historical pattern, documented in Chapter 5's discussion of Africa CDC, of infectious disease-dominated institutional investment.[185]

This concludes Part V's examination of frontier concerns. Part VI now offers synthesis, drawing together the theoretical, comparative, Ugandan, political-economy, and frontier analysis of Parts I through V into a concluding chapter and a consolidated set of constitutional, legislative, and judicial recommendations.

[184]State Council of the People's Republic of China, Healthy China 2030 Planning Outline (2016), explicitly linking NCD prevention targets to national economic competitiveness strategy.

[185]Africa CDC, Africa CDC Strategic Plan 2023-2027 (Africa CDC 2023), noting emerging institutional recognition of NCD surveillance integration into existing epidemic preparedness infrastructure.

PART VI — SYNTHESIS AND RECOMMENDATIONS

CHAPTER 17
TOWARD A PREVENTIVE CONSTITUTIONAL ORDER

17.1 Recapitulating the Argument

This monograph opened with a foundational proposition: that disease patterns are not determined solely by biology, genetics, or personal behaviour, but are substantially shaped by constitutional design, legal architecture, governance choices, institutional accountability, and the distribution of public power. Part I developed this proposition into three interlocking doctrines — Constitutional Epidemiology, Health Constitutionalism, and the Jurisprudence of Prevention — supplying, respectively, the diagnostic theory, the normative content of state duty, and the procedural and remedial mechanism for judicial enforcement.

Part II grounded these doctrines in a substantial body of existing international, African regional, and comparative constitutional authority, demonstrating that the theory advanced in this book is not a rupture with established law but a synthesis and extension of doctrine already recognised, in fragments, across the jurisdictions examined — the ICESCR's Article 12 and General Comment No. 14, the African Charter's Articles 16 and 24 and the SERAC precedent, and the comparative jurisprudence of South Africa, Kenya, India, Colombia, Brazil, the United States, and the United Kingdom.

Part III applied this synthesised framework to Uganda in sustained detail, finding a Constitution textually capable of grounding a composite health duty notwithstanding the absence of an express health right, a statutory and policy framework of uneven maturity — comparatively developed in tobacco control, substantially underdeveloped in food, alcohol, and environmental regulation — and an institutional and judicial record in which the principal doctrinal obstacle to structural health litigation, the political question doctrine, has already been cleared by the Supreme Court's decision in CEHURD.

Part IV examined the political economy of disease, situating the commercial determinants of health — tobacco, alcohol, sugar, and ultra-processed food — within the Health Constitutionalism duty to regulate harmful industries, and proposing Preventive Health Law as an independent legal discipline organised around ten

regulatory domains and operationalised through a proposed statutory Health Impact Assessment mechanism. Part V extended the analysis to frontier concerns — artificial intelligence, climate change, traditional medicine, and national security — demonstrating the theory's capacity for continued application as governance challenges evolve.

17.2 The Central Contribution

This monograph's central scholarly contribution is the demonstration that African constitutional law, and Ugandan constitutional law specifically, already possesses — through existing text, existing regional and international obligation, and existing judicial precedent — substantially sufficient doctrinal resources to treat non-communicable disease prevention as a justiciable constitutional concern, without requiring constitutional amendment as a precondition. The obstacles identified throughout this book are, in the main, not doctrinal but institutional, political, and strategic: chronic regulatory underfunding, incomplete industry-interference safeguards outside tobacco control, and the absence, to date, of a sustained civil society litigation strategy specifically targeting non-communicable disease governance.

> *The constitution most Africans live under already promises them protection from foreseeable, preventable death. What has been missing is not the promise, but the doctrinal imagination and institutional will to enforce it.*

17.3 Toward Judicial Practice: A Restated Three-Stage Framework

This chapter restates, for ease of practical reference, the three-stage preventive constitutional remedy developed in Chapter 3 and applied throughout Parts III and IV: first, the claimant establishes an evidentiary threshold of a well-documented, scientifically consensual link between specified regulatory or budgetary inaction and a serious, foreseeable, population-scale health risk; second, the court applies reasonableness review, following Grootboom, to assess whether the state's existing measures constitute a reasonable response, giving deference to resource constraints and policy choice while insisting on some rational, evidenced, good-faith programme of action; third, where the state's response is found unreasonable or, with respect to minimum core obligations, non-existent, the court issues a structural

remedy — declaration coupled with supervised implementation — rather than direct policy specification.

17.4 Limitations and Directions for Future Research

This monograph's limitations should be acknowledged candidly. First, the theory's application has been developed with reference to Uganda as principal case study; its extension to other African jurisdictions, while indicated throughout via comparative reference, would benefit from dedicated country-specific treatment. Second, the economic and fiscal costing of the recommendations proposed throughout this book, while indicated qualitatively, would benefit from dedicated quantitative research, particularly Uganda-specific NCD macroeconomic burden costing, identified as a priority research gap in Chapter 16. Third, the doctrine's judicial reception remains, at the time of writing, untested in the specific non-communicable disease context; the CEHURD precedent establishes the doctrinal pathway but has not yet been applied to the specific regulatory domains — food, alcohol, environmental health — examined in this book.

These limitations are offered not as concessions weakening the theory's claims, but as an invitation, consistent with the Preface's framing, to the sustained scholarly, judicial, and legislative engagement this monograph seeks to provoke.

17.5 Concluding Statement

Africa's rising non-communicable disease burden is, this monograph has argued throughout, not merely a medical crisis to be addressed by clinicians and epidemiologists, but a constitutional crisis calling for the sustained attention of jurists, legislators, and judges. Constitutional Epidemiology, Health Constitutionalism, and the Jurisprudence of Prevention together offer a doctrinal architecture capable of meeting that call — not as a finished orthodoxy, but as an opening contribution to a jurisprudence adequate to the epidemiological realities of the twenty-first century.

GENERAL CONCLUSION

This monograph set out to answer a question rarely posed with sufficient rigour in African constitutional scholarship: can constitutional law prevent disease before it occurs? The answer developed across seventeen chapters is a qualified but confident affirmative. Constitutional Epidemiology establishes that disease patterns are substantially shaped by constitutional design; Health Constitutionalism specifies the positive obligations that design must impose; and the Jurisprudence of Prevention supplies the doctrinal mechanism — evidentiary threshold, reasonableness review, structural remedy — through which courts may give those obligations practical effect.

Uganda's experience, examined in sustained detail across Part III, illustrates both the promise and the incompleteness of this framework in its present state of development. The constitutional and international legal resources are substantially present; the institutional will and litigation strategy to activate them have not yet caught up. The gap between these two conditions is precisely the space this monograph has sought to map, and precisely the space its recommendations, restated in consolidated form below, are addressed to closing.

The task now passes, as all scholarship of this kind must ultimately pass, from the page to practice — to the judges who will decide whether to extend CEHURD's logic to the non-communicable disease context; to the legislators who will decide whether to enact front-of-pack labelling and extend industry-interference safeguards beyond tobacco; to the civil society litigants who will decide whether to bring the first structural constitutional challenge to a health system that permits preventable death through regulatory neglect; and to the scholars, in Uganda and across Africa, who will take up, test, refine, and where necessary correct the theory this book has advanced.

CONSOLIDATED RECOMMENDATIONS

A. Constitutional and Judicial Recommendations

Recommendation 1: Purposive judicial recognition of a composite constitutional health duty

Ugandan courts should recognise, through purposive interpretation of Articles 21, 22, 24, 39, and 45, read together with Article 8A and Objectives XIV and XX of the National Objectives and Directive Principles of State Policy, a composite constitutional duty of health protection consonant with the six duties of Health Constitutionalism developed in Chapter 2, without awaiting constitutional amendment.

Recommendation 2: Adoption of the three-stage preventive remedy

Courts should adopt, building on the Supreme Court's clearance of the political question doctrine in CEHURD, the three-stage preventive constitutional remedy developed in Chapter 3 — evidentiary threshold, reasonableness review, structural remedy — as the operative framework for adjudicating systemic non-communicable disease governance claims.

Recommendation 3: Recognition of a minimum core in essential NCD medicines

Courts should recognise sustained, foreseeable unavailability of essential non-communicable disease medicines — insulin, basic chemotherapeutic agents, antihypertensives, and dialysis access for acute renal failure — as falling within the minimum core obligation identified in Chapter 4, not subject to a resource-constraint defence.

B. Legislative Recommendations

Recommendation 4: Front-of-pack warning labelling

Parliament should enact statutory front-of-pack warning labelling for food and beverage products exceeding WHO-recommended thresholds for sugar, salt, and saturated fat, following the Chilean and Mexican regulatory models examined in Chapter 10.

Recommendation 5: Restriction of marketing to children

Parliament should enact statutory restriction of the marketing of unhealthy food and

beverages to children across broadcast, digital, and school-adjacent advertising channels, consistent with WHO technical guidance examined in Chapter 10.

Recommendation 6: Extension of industry-interference safeguards

The Tobacco Control Act 2015's Section 4 industry-interference safeguard should be extended, by amendment or new legislation, to the alcohol and food and beverage regulatory domains, consistent with the SERAC v Nigeria duty to regulate harmful commercial conduct examined in Chapter 5.

Recommendation 7: Recalibration of excise taxation

Excise duty rates on sugar-sweetened beverages should be recalibrated, and indexed to inflation, to achieve the WHO-recommended threshold of at least a 20 per cent retail price increase, as examined in Chapter 8.

Recommendation 8: Statutory Health Impact Assessment

Parliament should enact a statutory Health Impact Assessment requirement, modelled on the National Environment Act 2019's environmental impact assessment framework, applicable to proposed legislation, regulation, and major public investment above a specified threshold, as developed in Chapter 11, including a specific equity-impact component for digital and AI-assisted health interventions as developed in Chapter 13.

Recommendation 9: Comprehensive alcohol control legislation

Parliament should enact comprehensive alcohol control legislation incorporating minimum unit pricing, marketing restriction, and industry-interference safeguards, as recommended in Chapter 10.

Recommendation 10: Traditional medicine registration framework

Parliament should enact the pending Traditional and Complementary Medicine Bill, incorporating the integrative regulatory model recommended in Chapter 15, including NCD warning-sign training and formal referral pathways for registered traditional practitioners.

C. Institutional and Policy Recommendations

Recommendation 11: Enhanced fiscal transfer for preventive health

Government should reconsider the fiscal architecture of decentralised health service

delivery, examined in Chapter 8, either through enhanced earmarked fiscal transfer to district local governments for preventive health programming or through reconsideration of the decentralisation framework's assignment of NCD prevention responsibility.

Recommendation 12: Uganda Human Rights Commission engagement

The Uganda Human Rights Commission should deploy its existing investigatory powers under Article 52 of the Constitution to conduct systemic investigation of non-communicable disease governance failures, as recommended in Chapter 9.

Recommendation 13: Civil society litigation strategy

Civil society organisations with public interest litigation capacity should develop a dedicated non-communicable disease litigation strategy, deploying the CEHURD precedent, Article 39 environmental jurisprudence, and the National Environment Act's standing provisions, as recommended in Chapter 9.

Recommendation 14: Integration of NCD indicators into national security planning

The National Security Council framework and National Development Plans should explicitly incorporate non-communicable disease burden indicators into national security and development risk assessment, as recommended in Chapter 16.

Recommendation 15: Uganda-specific NCD macroeconomic costing

Government, in partnership with academic and multilateral research institutions, should commission comprehensive Uganda-specific costing of the non-communicable disease burden's macroeconomic and fiscal impact, identified as a priority research gap in Chapters 16 and 17.

BIBLIOGRAPHY

International Instruments and Materials

International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3.

UN Committee on Economic, Social and Cultural Rights, General Comment No. 3: The Nature of States Parties' Obligations UN Doc E/1991/23 (14 December 1990).

UN Committee on Economic, Social and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) UN Doc E/C.12/2000/4 (11 August 2000).

Constitution of the World Health Organization (adopted 22 July 1946, entered into force 7 April 1948).

WHO Framework Convention on Tobacco Control (adopted 21 May 2003, entered into force 27 February 2005) 2302 UNTS 166.

Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3.

Convention on the Elimination of All Forms of Discrimination against Women (adopted 18 December 1979, entered into force 3 September 1981) 1249 UNTS 13.

UN Convention on the Rights of Persons with Disabilities (adopted 13 December 2006, entered into force 3 May 2008) 2515 UNTS 3.

Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from their Utilization (adopted 29 October 2010, entered into force 12 October 2014).

UN General Assembly, Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases UN Doc A/RES/66/2 (2011).

Rio Declaration on Environment and Development (adopted 14 June 1992) UN Doc A/CONF.151/26 (vol I).

UN Development Programme, Human Development Report 1994: New Dimensions of Human Security (UNDP, New York 1994).

African Regional Instruments and Materials

African Charter on Human and Peoples' Rights (adopted 27 June 1981, entered into force 21 October 1986) 1520 UNTS 217.

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (adopted 11 July 2003, entered into force 25 November 2005).

African Charter on the Rights and Welfare of the Child (adopted 11 July 1990, entered into force 29 November 1999).

African Commission on Human and Peoples' Rights, Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights (2011).

African Union, Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious

Diseases (2001).

African Union, Africa Health Strategy 2016-2030 (African Union Commission 2016).

Social and Economic Rights Action Center (SERAC) and Center for Economic and Social Rights (CESR) v Nigeria, Comm No 155/96 (African Commission on Human and Peoples' Rights, 27 October 2001).

Ugandan Legislation and Constitutional Materials

Constitution of the Republic of Uganda, 1995 (as amended).

Public Health Act, Cap 281 (Uganda).

Tobacco Control Act 2015 (Uganda).

National Environment Act 2019 (Uganda).

Food and Drugs Act, Cap 278 (Uganda).

Excise Duty Act 2014 (Uganda), as amended.

Local Governments Act, Cap 138 (Uganda).

Data Protection and Privacy Act 2019 (Uganda).

Mental Health Act 2019 (Uganda).

Persons with Disabilities Act 2020 (Uganda).

Industrial Property Act 2014 (Uganda).

Kampala Capital City Authority Act 2010 (Uganda).

National Health Insurance Scheme Bill (Uganda, pending).

Traditional and Complementary Medicine Bill (Uganda, pending).

Ugandan and Regional Case Law

Attorney General v Salvatori Abuki [1999] UGCC (Constitutional Court of Uganda).

Attorney General v Uganda Law Society [2020] UGSC (Supreme Court of Uganda).

Center for Health, Human Rights and Development (CEHURD) and Others v Attorney General, Constitutional Petition No 16 of 2011 (Constitutional Court of Uganda).

Center for Health, Human Rights and Development (CEHURD) and Others v Attorney General, Constitutional Appeal No 1 of 2013 (Supreme Court of Uganda).

Comparative Constitutional Materials and Case Law

Constitution of the Republic of South Africa, 1996.

Constitution of Kenya, 2010.

Constitution of India.

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

Government of the Republic of South Africa v Grootboom 2001 (1) SA 46 (CC).

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

Francis Coralie Mullin v Administrator, Union Territory of Delhi (1981) 1 SCC 608 (Supreme Court of India).

M.C. Mehta v Union of India AIR 1987 SC 1086 (Supreme Court of India).

Vellore Citizens' Welfare Forum v Union of India (1996) 5 SCC 647.

Minerva Mills Ltd v Union of India AIR 1980 SC 1789.

T-025 de 2004 (Constitutional Court of Colombia, 22 January 2004).

T-760 de 2008 (Constitutional Court of Colombia, 31 July 2008).

DeShaney v Winnebago County Department of Social Services, 489 US 189 (1989).

United States v Philip Morris USA Inc, 449 F Supp 2d 1 (DDC 2006).

Osman v United Kingdom App No 23452/94 (ECtHR, 28 October 1998).

Regulation (EU) 2024/1689 (EU Artificial Intelligence Act).

Health Act 2006 (UK).

Finance Act 2017 (UK).

Traditional Medicine Practice Act 2000 (Ghana).

Traditional Health Practitioners Act 2007 (South Africa).

Environmental Management and Co-ordination Act 1999 (Kenya).

Ministry of Health, Chile, Law 20.606 on Nutritional Composition of Food and Advertising (2016).

Books, Articles, and Reports

David Bilchitz, Poverty and Fundamental Rights: The Justification and Enforcement of Socio-Economic Rights (Oxford University Press 2007).

Scott Burris, Micah Berman, Matthew Penn and Tara Ramanathan Holiday (eds), The Legal Epidemiology of Chronic Disease Prevention (Public Health Law Research, Temple University, 2016).

Guido Calabresi, The Costs of Accidents: A Legal and Economic Analysis (Yale University Press 1970).

Camila Corvalán, Marcela Reyes, María Luisa Garmendia and Ricardo Uauy, 'Structural Responses to the Obesity and Non-Communicable Diseases Epidemic: The Chilean Law of Food Labeling and Advertising' (2013) 14 Obesity Reviews 79.

Owen M. Fiss, 'The Supreme Court 1978 Term — Foreword: The Forms of Justice' (1979) 93 Harvard Law Review 1.

Octavio Luiz Motta Ferraz, 'Harming the Poor through Social Rights Litigation: Lessons from Brazil' (2011) 89 Texas Law Review 1643.

Sharon Friel, Anne Marie Thow, Robert Peralta and Rob Moodie, 'Commercial Determinants of Health', The Lancet Series (2023).

Barry R. Furrow and others, Health Law: Cases, Materials and Problems (8th edn, West Academic 2018).

Anna B. Gilmore and others, 'Defining and Conceptualising the Commercial Determinants of Health' (2023) 401 The Lancet 1194.

Lawrence O. Gostin, Public Health Law and Ethics: A Reader (2nd edn, University of California Press 2010).

Lawrence O. Gostin and Lindsay F. Wiley, Public Health Law: Power, Duty, Restraint (3rd edn, University of California Press 2016).

Scott L. Greer, 'The Territorial Politics of Health Policy' in Scott L. Greer (ed), Territory, Democracy and Justice (Palgrave Macmillan 2006).

Varun Gulshan and others, 'Development and Validation of a Deep Learning Algorithm for Detection of Diabetic Retinopathy in Retinal Fundus Photographs' (2016) 316 JAMA 2402.

Jeff King, Judging Social Rights (Cambridge University Press 2012).

Nancy Krieger, 'Theories for Social Epidemiology in the 21st Century: An Ecosocial Perspective' (2001) 30 International Journal of Epidemiology 668.

Carlos A. Monteiro and others, 'Ultra-Processed Foods: What They Are and How to Identify Them' (2019) 22 Public Health Nutrition 936.

H.W.O. Okoth-Ogendo, 'Constitutions without Constitutionalism: Reflections on an African Political Paradox' in Douglas Greenberg and others (eds), Constitutionalism and Democracy: Transitions in the Contemporary World (Oxford University Press 1993).

Ziad Obermeyer and others, 'Dissecting Racial Bias in an Algorithm Used to Manage the Health of Populations' (2019) 366 Science 447.

Katharina Pistor, 'A Legal Theory of Finance' (2013) 41 Journal of Comparative Economics 315.

George J. Stigler, 'The Theory of Economic Regulation' (1971) 2 Bell Journal of Economics and Management Science 3.

Cass R. Sunstein, 'Against Positive Rights' (1993) 2 East European Constitutional Review 35.

Elizabeth Tobin Tyler and others (eds), Poverty, Health and Law: Readings and Cases for Medical-Legal Partnership (Carolina Academic Press 2011).

Transparency International, Global Corruption Report: Corruption in the Health Sector (Transparency International 2006).

David J.P. Barker, 'The Origins of the Developmental Origins Theory' (2007) 261 Journal of Internal Medicine 412.

Engineer Bainomugisha and others, 'AirQo: An IoT-Enabled Air Quality Monitoring Solution for Urban Environments in Developing Countries' (2019) IEEE Global Humanitarian Technology Conference.

Nick Watts and others, 'The 2023 Report of the Lancet Countdown on Health and Climate Change' (2023) 402 The Lancet 2346.

FAO, IFAD, UNICEF, WFP and WHO, The State of Food Security and Nutrition in the World 2023 (FAO, Rome 2023).

World Health Organization and Other Institutional Reports

WHO, Noncommunicable Diseases Progress Monitor 2022 (WHO, Geneva 2022).

WHO, Global Action Plan for the Prevention and Control of NCDs 2013-2030 (WHO, Geneva 2013).

WHO, WHO Report on the Global Tobacco Epidemic 2021: Addressing New and Emerging Products (WHO, Geneva 2021).

WHO, Ambient Air Pollution: A Global Assessment of Exposure and Burden of Disease (WHO, Geneva 2016).

WHO Commission on Social Determinants of Health, Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health (WHO, Geneva 2008).

WHO, Manual on Sugar-Sweetened Beverage Taxation Policies to Promote Healthy Diets (WHO, Geneva 2022).

WHO, Set of Recommendations on the Marketing of Foods and Non-Alcoholic Beverages to Children (WHO, Geneva 2010).

WHO, Global Status Report on Alcohol and Health 2018 (WHO, Geneva 2018).

WHO, REPLACE Trans Fat: An Action Package to Eliminate Industrially Produced Trans-Fatty Acids (WHO, Geneva 2018).

WHO, Global Report on Urban Health: Equitable, Healthier Cities for Sustainable Development (WHO, Geneva 2016).

WHO, WHO Global Air Quality Guidelines: Particulate Matter, Ozone, Nitrogen Dioxide, Sulfur Dioxide and Carbon Monoxide (WHO, Geneva 2021).

WHO, Global Strategy on Digital Health 2020-2025 (WHO, Geneva 2021).

WHO, Traditional Medicine Strategy 2014-2023 (WHO, Geneva 2013).

WHO Regional Office for Africa, WHO Traditional Medicine Strategy 2014-2023: African Region Implementation (WHO 2016).

WHO Regional Office for Africa, Noncommunicable Diseases and Poverty: The Need for Pro-Poor Strategies in the African Region (WHO 2011).

WHO and World Economic Forum, From Burden to 'Best Buys': Reducing the Economic Impact of Non-Communicable Diseases in Low- and Middle-Income Countries (WHO, Geneva 2011).

International Agency for Research on Cancer, Global Cancer Observatory: Cervical Cancer Fact Sheet (IARC 2022).

Public Health England, Salt Reduction Targets for 2024 (Public Health England 2020).

Ministry of Health, Uganda, National Non-Communicable Diseases Strategic Plan (Ministry of Health, Kampala).

Ministry of Health, Uganda, Annual Health Sector Performance Report (various years).

Ministry of Health, Uganda, WHO FCTC Implementation Report (Ministry of Health, Kampala, various years).

Ministry of Health, Uganda, Mental Health Investment Case (Ministry of Health, Kampala 2021).

Ministry of Water and Environment, Uganda, National Climate Change Policy (2015).

Ministry of Education and Sports, Uganda, School Health Policy (draft).

Parliament of Uganda, Committee on Health, Reports on Ministerial Policy Statements, Ministry of Health (various years).

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ABOUT THIS BOOK

This book pioneers a jurisprudential framework for understanding how constitutional design, governance, law, and public institutions influence the burden, distribution, and prevention of non-communicable diseases (NCDs) in Africa.

It examines the constitutional determinants of health—accountability, equity, participation, rights, and intersectoral governance—and argues that good. constitutionalism is preventive constitutionalism.

With special reference to Uganda and comparative constitutional democracies, this work bridges law, public policy, and epidemiology to advance a new paradigm: Constitutional Epidemiology.

KEY THEMES

- Health Constitutionalism in Africa
- Constitutional Determinants of NCDs
- The Right to Health and Preventive Obligations
- Governance, Institutions and Policy Coherence
- Social Determinants and Structural Risk
- Comparative Constitutional Perspectives
- Uganda's Constitutional Journey and Health Outcomes
- Towards a Jurisprudence of Prevention

THIS BOOK IS FOR

- Scholars of Law, Public Health & Governance
- Policy Makers and Public Institution Leaders
- Health Professionals and Researchers
- Students of Law, Public Policy & Medicine
- Civil Society and Development Partners
- All who believe that constitutional design can prevent disease and promote well-being

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