

ADVOCATING FOR THE RIGHT TO REPRODUCTIVE HEALTHCARE IN UGANDA

The import of Constitutional Petition No.16 of 2011

October 2011



CEHURD
social justice in health

International
Alliance



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FOREWORD

This brief aims to explain the context of landmark petition the Center for Health, Human Rights and Development (CEHURD) and other partners have filed in the Constitutional Court seeking to secure among others a declaration that non-provision of essential maternal health commodities in a government health facilities, leading to the death of some expectant mothers, is an infringement on the right to health of the victims.

In addition, this brief illustrates the nature of obligations the Uganda government has towards reproductive health as a human right in Uganda.

The importance of Constitutional Petition No.16 of 2011 lies in the fact that it is the first time we as human rights advocates are using litigation as an advocacy strategy, and in the rest of this brief, we demonstrate that regardless of outcome, a precedent has already been set upon which future we can build in future work.

It is our sincere hope that this brief should help us rally support for the debate on the government's immediate obligations and inspire advocacy on the subject of reproductive health care as a fundamental human right in Uganda.

We extend our sincere thanks to all our partners in this petition and in this report, including Open Society Institute and International HIV/AIDS Alliance Uganda.

Moses Mulumba

Executive Director

CEHURD: Center for Health, Human Rights & Development



ABBREVIATIONS & ACRONYMS

ACHPR	African Charter on Human and People’s Rights
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
CRPWD	Convention on the Rights of Persons With Disabilities
EmOC	Emergency obstetric care
EOC	Equal Opportunities Commission
HSSP III	Third Health Sector Strategic Investment Plan (2010/11–2014/15)
ICESCR	International Covenant on Economic, Social and Cultural Rights
MDGs	Millennium Development Goals
NDP	National Development Plan
NHP	National Health Policy
NODPSP	National Objectives and Directive Principles of State Policy
PPC	Post-partum care
STI	Sexually transmitted infection
UDHR	Universal Declaration of Human Rights
UHRC	Uganda Human Rights Commission
WHO	World Health Organisation

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INTRODUCTION

1.1 Litigation as an advocacy strategy

Litigation is a powerful tool for human rights advocacy. This is because it helps to clarify the obligations of the state and transforms them into legal duties the state must implement. Litigation also helps to bring into the public arena matters of human rights concern, and once successful, judgments become tools of advocacy for human rights activists. In addition, it provides a unique opportunity to mobilise and rally different actors around a common cause and, even when the final ruling is not favourable, the process will create long-term partnerships, coalitions and networks that could be important in future work.

In spite of its many strengths, it is important to note that using litigation as an advocacy tool in isolation will bring only limited success. Indeed, the success of litigation in bringing about change very much depends on what happens outside the court. For this reason, litigation must be complemented and supported by other non-judicious strategies, such as political lobbying, media campaigns, public mobilisation, among others.

These complementary strategies are important in preparing the ground for implementation of the outcomes of the case and may in some cases induce the desired changes even before judgment is handed down or implemented. They will also help generate vital information for use in the case. For these reasons, it is important to put out in the public arena as much information as is there about an on-going case.

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Constitutional Petition No. 16 of 2011 – Center for Health, Human Rights and Development & Others V Attorney General – represents the first time civil society advocacy organisations are using litigation as a strategy to advance human rights in Uganda.

This report highlights litigation as an advocacy strategy

1.2 Purpose and organisation of the report

The Center for Health, Human Rights and Development (CEHURD) commissioned this work to explain the context of the Constitutional Court case. This work is intended as to, among others, serve as a tool to rally public support for the case and inspire advocacy on the subject of reproductive healthcare in Uganda. This report also highlights litigation as an advocacy strategy that could be used by human rights activists and encourage its adoption on other health and health-related human rights.

The publication further illustrates reproductive health as a human right by detailing different international and regional standards on which this right is based. The status of reproductive health is highlighted, with the aim of demonstrating the fact that the incidents that gave rise to Constitutional Petition 16 are widespread and are affecting hundreds of women.

Finally, the report makes a comparative assessment of how the right to health generally and reproductive health in particular have been handled by judicial and quasi-judicial bodies at national and international levels.

RIGHT TO REPRODUCTIVE HEALTH IN INTERNATIONAL HUMAN RIGHTS LAW

The right to health, described as “the right to the highest attainable standard of health”, is recognised and protected by a number of international human rights instruments.

2.1 The Universal Declaration of Human Rights

The Universal Declaration of Human Rights (UDHR) protects the right to health as a vital component of the right to an adequate standard of living and health. A special provision is also made for the protection of motherhood and childhood. The UDHR has gained recognition as an expression of principles of customary international law which all nations are under duty to observe.

2

UNIVERSAL DECLARATION OF HUMAN RIGHTS

Article 25: Right to an adequate standard of living and health

1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

INTERNATIONAL
COVENANT ON
ECONOMIC, SOCIAL AND
CULTURAL RIGHTS

Article 12: Right to health

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
 - a) The provision for the reduction of the still-birth rate and infant mortality and for the healthy development of the child;
 - b) The improvement of all aspects of environmental and industrial hygiene;
 - c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
 - d) The creation of conditions that would assure to all medical service and medical attention in the event of sickness

2.2 The International Covenant on Economic, Social and Cultural Rights

The is the International Covenant on Economic, Social and Cultural Rights (ICESCR) is the most authoritative international human rights instrument protecting the right to health, described as “the right to the highest attainable level of physical and mental health”. As an international treaty, the ICESCR is one of the most binding international human rights instruments.

2.3 The Convention on the Rights of the Child

The Convention on the Rights of the Child (CRC) guarantees every child the right to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. The provision requires states to diminish infant and child mortality, and to ensure that no child is deprived of access to health care services.

CONVENTION ON THE
RIGHTS OF THE CHILD

Article 24: The right to
health of the child

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.
2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
 - a) To diminish infant and child mortality;
 - b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care; ...
 - d) To ensure appropriate pre-natal and post-natal health care for mothers; ...
 - (f) To develop preventive health care, guidance for parents and family planning education and services. ...

CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES

Article 25: Health

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability...

In particular, States Parties shall:

- a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;
- b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;

...

2.4 The Convention on the Rights of Persons with Disabilities

The Convention on the Rights of Persons with Disabilities (CRPWD) guarantees people with disabilities the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability, and requires states to take all appropriate measures to ensure access for persons with disabilities to health services that are gender sensitive, including health-related rehabilitation.

2.5 The Convention on the Elimination of All Forms of Discrimination Against Women

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) is more specific on how the right to health relates to women.

2.6 The African Charter on Human and Peoples Rights

At the continental level, the right is protected by the African Charter on Human and Peoples Rights (ACHPR) guarantees the right to enjoy the best attainable state of physical and mental health in Article 16.

CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN

Article 12: Health

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
2. Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

AFRICAN CHARTER ON HUMAN AND PEOPLES RIGHTS

Article 16

1. Every individual shall have the right to enjoy the best attainable state of physical and mental health.
2. States Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

**AFRICAN CHARTER
ON THE RIGHTS AND
WELFARE OF THE CHILD**

**Article 14: Health and
Health Services**

1. Every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health.
2. States Parties to the present Charter shall undertake to pursue the full implementation of this right and in particular shall take measures:
 - (a) to reduce infant and child mortality rate;
 - (b) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
...
 - (f) to ensure appropriate health care for expectant and nursing mothers;
...

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

The African Charter on the Rights and Welfare of the Child guarantees the African child the right to the best attainable state of physical, mental and spiritual health. This provision requires states to among others take measures to reduce infant and child mortality in addition to ensuring appropriate health care for expectant and nursing mothers.

2.8 The Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa

The Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa, which in Article 14 protects what it describes as health and reproductive health rights.

**PROTOCOL TO THE
AFRICAN CHARTER ON
HUMAN AND PEOPLES
RIGHTS ON THE RIGHTS
OF WOMEN IN AFRICA**

**Article 14: Health and
Reproductive Rights**

1. States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted.
2. States Parties shall take all appropriate measures to:
...
 - b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding;

3

REPRODUCTIVE HEALTH AS AN ELEMENT OF RIGHT TO HEALTH

The reproductive function of women, unlike of men, comes with a whole range of challenges:

- inadequate levels of knowledge about human sexuality and inappropriate or poor quality reproductive health information and services;
- the prevalence of high risk sexual behaviour;
- discriminatory social practices;
- negative attitudes towards women and girls;
- the limited power women and girls have over their reproductive lives; and
- the high levels of infant and maternal mortality and morbidity rates.

3.1 Women's unique health needs

One of the biggest challenges facing women in all aspects of life is discrimination. Discrimination against women has been defined as any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

The recognition and protection of the right to health is broadly, among others, made on the basis that women and men are equal, with equal entitlement to protection of their rights. For this reason, it is important that all aspects of discrimination in all settings are addressed. In addition to this, however, it is important to recognize the fact that although women should be treated on the same basis as men, they face unique challenges related to their gender that require specific attention.

3.2 Framing women's right to reproductive health

The unique reproductive health needs of women flag their right to reproductive health as an element of the right to health. Reproductive health as a component of the right to health also needs to be understood in the context of some elements of the rights of children, especially those which assure children the right to health and commit states to the reduction of infant and child mortality. In addition, the high rates of maternal and infant mortality have been recognised as challenges that require, among others, a human rights response.

In 2009, the United Nations Human Rights Council adopted a resolution titled, "Preventable Maternal and Morbidity and Human Rights". In this resolution, the Council recognises the fact that the unacceptably high rates of preventable maternal mortality and morbidity is a health, development and human rights challenge. The Council stated that the integration of a human rights perspective in international and national responses to maternal mortality and morbidity could contribute positively to the common goal of reducing preventable maternal mortality and morbidity.

3.3 The right to reproductive health in human rights instruments

The Committee on Economic, Social and Cultural Rights has indicated that the ICESCR provision for the reduction of stillbirths and infant mortality – needed for the healthy development of the child – may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as resources necessary to act on the information..

The Committee has also stated that eliminating discrimination against women requires development of a comprehensive national strategy for promoting women's right to health throughout their life span. Such a strategy should include interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high quality and affordable health care, including sexual and reproductive services.

The right to reproductive health has been recognized by CEDAW, the ICESCR and other international human rights instruments.

A major goal should be reducing women's health risks, particularly lowering rates of maternal mortality and protecting women from domestic violence.

One of the most explicit instruments protecting the reproductive health rights of women is the Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa. This instrument is drafted in a manner that protects the rights of women from an African perspective.

Additionally, the Committee notes that the realisation of the women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health. That it is also important to undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights.

PROTOCOL ON THE RIGHTS OF WOMEN IN AFRICA

Article 14, Health and Reproductive Rights

1. States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted.

This includes:

- a) the right to control their fertility;
 - b) the right to decide whether to have children, the number of children and the spacing of children;
 - c) the right to choose any method of contraception;
 - d) the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS;
 - e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices; the right to have family planning education.
2. States Parties shall take all appropriate measures to:
 - a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas;
 - b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding;
 - c) protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.

THE RIGHT TO HEALTH IN UGANDA'S LAWS

4.1 The right to health in the Uganda Constitution

The legal basis of the right to health is the national Constitution of 1995, which is the supreme law in Uganda. Section of the Constitution's National Objectives and Directive Principles of State Policy (NODPSP) is dedicated to the protection and promotion of fundamental and other human rights and freedoms.

Objective XIV requires the state to endeavour to fulfil the fundamental rights of all Ugandans to social justice and economic development and in particular among others to ensure that all Ugandans enjoy rights and opportunities and access to education, health services, clean and safe water, work, decent shelter, adequate clothing, food security and pension and retirement benefits.

In 2005, a Constitutional amendment introduced Article 8A, a provision which strengthens the application of the NODPSP and affirms their legal status.

Article 8A is important because it gives the objectives and principles full legal effect. This means that the objectives and principles can be used in litigation requiring the interpretation of the Constitution. Any reading of the Constitution should integrate the objectives and principles, which should also guide interpretation.

It is important to note that the judicial enforceability of the objectives and principles was given effect to by the

The Constitution of Uganda lacks a substantive provision on the right to health but makes mention of the right under other provisions (Mulumba, et. al, 2010)

OBJECTIVE XX OF THE CONSTITUTION RELATES TO MEDICAL SERVICES AND PROVIDES THAT:

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

8A. NATIONAL INTEREST

- (1) Uganda shall be governed based on the principles of national interest and common good enshrined in the national objectives and directive principles of state policy.
- (2) Parliament shall make laws for the purposes of giving full effect to clause (1) of the Article

UGANDA CONSTITUTION

33. Rights of women

- (1) Women shall be accorded full and equal dignity of the person with men.
- (2) The State shall provide the facilities and opportunities necessary to enhance the welfare of women to enable them to realise their full potential and advancement.
- (3) The State shall protect women and their rights, taking into account their unique status and natural maternal functions in society.
- (4) Women shall have the right to equal treatment with men and that right shall include equal opportunities in political, economic and social activities.
- (5) Without prejudice to article 32 of this Constitution, women shall have the right to affirmative action for the purpose of redressing the imbalances created by history, tradition or custom.
- (6) Laws, cultures, customs or traditions which are against the dignity, welfare or interest of women or which undermine their status, are prohibited by this Constitution.

Constitutional Court of Uganda way back before the adoption of Article 8A. In the case of *Salvatori Abuki and Anor v Attorney General* (Constitutional Case No. 2 of 1997), the Court endorsed an approach adopted by the Indian Supreme Court to the effect that elements of the NODPSP can be used in interpreting the Constitution.

In India, the NODSP have been used to find that the right to life when read in conjunction with the NODPSP includes the right to a livelihood. In some cases the right to life has been defined to include the right to health. The Court in the *Abuki* case came to the conclusion that the banishment of the Petitioner from his home under the Witchcraft Act, thereby depriving him of shelter, food and essential sustenance infringed his right to life in light of Objective XIV, which as indicated above imposes an obligation on the state to ensure that all Ugandans access health services, food and shelter among others.

The right to health for women in general and reproductive health in particular is also to be found in Article 33 of the Constitution, which guarantees the rights of women. This provision guarantees the dignity of women, their equality with men and provides them with special protection.

4.2 Uganda's framework for the enforcement of the right to health

The Constitutional Court

The Constitution of Uganda empowers the Judiciary to exercise judicial power “in the name of the people and in conformity with the law and values, norms and aspirations of the people”. The Constitution (Article 129) constitutes different courts and defines a hierarchy which includes the Supreme Court, as the most superior court, followed by the Court of Appeal, which also sits as the Constitutional Court whenever it becomes necessary to interpret the Constitution. The Court of Appeal is followed by the High Court and subordinate courts which could include magistrate courts, courts martial, and local council courts.

The right to petition the Constitutional Court is provided for in Article 137(3).

In addition to the Constitutional Court, the High Court has jurisdiction to deal with constitutional matters where a litigant is seeking to enforce a right protected by the Constitution. Article 50(1) allows any person who claims that a fundamental or other right or freedom guaranteed under the Constitution has been infringed or threatened to apply to court for redress, which may include compensation. In this regard, Article 50(2) allows any person or organisation to bring an action against the violation of another person's or group's human rights.

Uganda Human Rights Commission

In addition to the formal courts, the human rights protected by the Constitution can be enforced in such institutions as the Uganda Human Rights Commission (UHRC) and the Equal Opportunities Commission (EOC). The UHRC is constituted

137. QUESTIONS AS TO THE INTERPRETATION OF THE CONSTITUTION

...

(3) A person who alleges that—

- a) an Act of Parliament or any other law or anything in or done under the authority of law; or
- b) any act or omission by any person or authority,

is inconsistent with or in contravention of a provision of this Constitution, may petition the constitutional court for a declaration to that effect, and for redress where appropriate

The laws across the countries focus primarily on the control of STIs and on the nature of sexual offences against vulnerable groups (through more recent laws linked to HIV). While these laws provide some level of public health intervention, vulnerable groups such women and children do not know or exercise their rights...

There are still weak mechanisms for investigating and prosecution of sexual abuse cases, particularly through 'victim friendly legal and court processes' (Kasimbazi, et. al, 2008)

by the Constitution (Article 51) and is mandated to among others, investigate the violation of any human rights. The Constitution (Article 53(1)) empowers the Commission to exercise a number of judicial powers in discharging its functions. This includes issuing summons for attendance of persons or production of evidence, and is empowered to order, among others, any legal remedy or redress.

The Equal Opportunities Commission

The Equal Opportunities Commission (EOC) is established by Article the Constitution read in conjunction with the Equal Opportunities Commission Act, passed by Parliament in 2007.

The Commission is empowered to investigate or inquire into, on its own initiative or on a complaint made by any person or group of persons, any act, circumstance, conduct, omission, programme, activity or practice which seems to amount to or constitute discrimination, marginalization or to otherwise undermine equal opportunities. In discharging this function the EOC Act empowers the Commission to proceed judiciously. In light of these provisions, the EOC could used to enforce of variety of rights were evidence of discrimination exists. As is indicated below, the denial of reproductive health care services could legally be viewed as a form of discrimination against women.

EQUAL OPPORTUNITIES COMMISSION

The broad function of the EOC is to monitor, evaluate and ensure that policies, laws, plans, programs, activities, practices, traditions, cultures, usages and customs of among others organs of state at all levels, private businesses and enterprises, and social and cultural communities, are compliant with equal opportunities and affirmative action in favour of groups marginalized on the basis of sex, race, colour, ethnic origin, tribe, creed, religion, social or economic standing, political opinion, disability, gender, age or any other reason created by history, tradition or custom.

THE RIGHT TO HEALTH IN UGANDA'S POLICY

Uganda has ratified all the major international human rights instruments, which means that the country has an obligation to protect the rights that the various declarations, covenants and treaties define and protect. This requires the country to ensure that the rights are not only provided for in the domestic legal and policy framework but also protected through enforcement and implementation of the relevant laws and policies.

Indeed, Uganda has adopted several policies and laws, including the Constitution, which protect the right to health. There are a number of policies that deal with health generally and specific aspects of care. Some of the key policies and laws are highlighted in this section.

5.1 The National Health Policy

The overall objective of the *National Health Policy 2009* (NHP) is to ensure a good standard of health for all people in Uganda. In the policy, the state commits to the promotion of access to education, health services and clean and safe water. This is in addition to investing in and promoting people's health to ensure that they remain productive and contribute to national development.

The policy deals with a number of issues, including determinants of health, organisation and management of the health sector; health service delivery; the public health delivery system; the role of the private and private subsectors; research, legislation and enforcement; health resources that include health supplies and human resources by looking into infrastructure and financing, strategies, monitoring and evaluation.

The National Health Policy 2009 emphasizes the promotion of people's health in a manner consistent with Constitutional provisions on health and the mandate of the state to provide basic medical services and promote good nutrition.

The Policy notes a number of positive health indicators such as the improvement of the life expectancy from 45 years in 2003 to 52 years in 2008, the stabilisation of the HIV prevalence rate and the eradication of polio and guinea worm. Nonetheless, the Policy acknowledges that the health of Ugandans is still too poor. It is indicated that there is the need to improve on this through increased budgetary expenditure on medical commodities and services is demanding..

5.2 The Health Sector Strategic Investment Plan

The *Health Sector Strategic Plan III 2010/11–2014/15* (HSSP III) was formulated to guide investments in the health sector for the next five years (July 2010-June 2015). The HSSP III provides an overall framework with the major aim of among others contributing towards the overall development goal of the Government in accelerating economic growth and reducing poverty as stated in the National Development Plan (NDP) 2010/11-2014/15. The HSSP III has identified key challenges facing Uganda's health system and makes commitment to address these. It also sets priorities and key areas on which to focus health investment in the medium term, for both public and private partners to contribute to the attainment of both the health sector goals and the national goals as outlined in the NDP.

The most striking aspect of HSSP III when compared to its predecessors, HSSP I and HSSP II, is the express recognition that health is a human right and derives from international instruments.

On maternal health care, the Policy acknowledges the fact that not much progress has been made with respect to Millennium Development Goal 5 (MDG 5) which requires

states to improve maternal health by 2015. It is indicated that Uganda is unlikely to achieve that the target of MDG 5, unless deliberate or strategic investments are made to accelerate progress.

5.3 The National Adolescent Health Policy

Reproductive health issues affecting adolescents are dealt with in the *National Adolescent Health Policy, 2004*. This Policy documents the commitment of the Government to integrate young people in the development processes. It complements all sectoral policies and programmes and defines structures and key target areas for ensuring that adolescent health concerns are mainstreamed in all planning activities.

The policy recognises the critical roles adolescents can play in promoting their own health and development and emphasises the need for their involvement in planning, implementation, monitoring and evaluation of programmes within the context of the economic, social, cultural, and spiritual realities of Uganda without giving in to those aspects that are harmful and dangerous to the health of adolescents. This is in addition to strengthening and promoting an enabling social and legal environment for the provision of high quality, accessible adolescent health services.

The targets the policy sets if implemented could improve the reproductive health of adolescents and also improve the quality of services that adolescents receive in maternal contexts. The targets include:

- (a) doubling the contraceptive use rate among sexually active adolescents; reducing first childbirth by half from 59% to 30% (the proportion of women who have their first child below 20 years);

HSSP III, para 5.4.1.

The 1995 Uganda Constitution (as amended) guarantees rights of access for all people in Uganda to basic health care services as well as the right to food and nutrition security. The right to health therefore is not only a right to quality health care but also a right to other determinants of health such as safe and adequate water supply, sanitation, education, food and a right to a safe environment among others.

The National Adolescent Health Policy it seeks to promote and advance gender, equity and equality emphasizing the elimination of all forms of gender bias, discrimination and violence using a multi-sectoral approach.

HSSP III, para 5.4.1.

Health as a human right is enshrined in several legal instruments that Uganda has ratified. The instruments declare health as a fundamental human right to be enjoyed by all without discrimination and these include the WHO constitution; International Covenant on Economic, Social and Cultural Rights (ICESCR), Convention on the Rights of the Child (CRC), International Convention on the Elimination of all forms of Discrimination against Women (CEDAW), the African Charter on People's Rights (ACHPR) and several others.

- (b) raising the age of first sexual intercourse to 18 years from 16.7;
- (c) increasing the proportion of adolescents abstaining from sex before marriage increased by 30%;
- (d) increasing protection/safe sex among sexually active adolescent by 30%;
- (e) increasing practice of dual protection in sex (against both disease and pregnancy) among adolescents by 30%;
- (f) integrating post-abortion care in all health centres HCIV, HCIII, HCII, HCI and arranging appropriate primary health care facilities with emphasis on post abortion family planning counselling and services;
- (g) ensuring that pregnant school girls continue with education after they have delivered; and
- (h) reviewing abortion law with a view to improve the services.

5.4 The National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights

The *National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights, 2006* is a policy intended to address the need for explicit direction and focus, as well as to streamline the training and provision of reproductive health services. It provides a framework for guiding reform and development of a results oriented national reproductive health program. The Policy also seeks to make reproductive health programmes and services accessible and affordable to the majority of the target groups.

The policy guidelines aim to promote reproductive health rights which it defines to include: the right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children; the right to information and means to make the decisions as stated above; the right to attain the highest standard of sexual and reproductive health; and the right to make decisions concerning reproduction, free of discrimination, coercion and violence.

The priorities for reproductive health include: safe motherhood including breast feeding and nutrition, pre-natal care, safe delivery and post-natal care; information, education and counselling on reproductive health and sexuality; abortion and post-abortion care; family planning; and adolescent reproductive health.

5.5 The Reproductive Health Policy

Like the Adolescent Policy, the Reproductive Health Policy details the need for proper adolescent health and lists a variety of services to be provided to adolescents, including family planning, emergency contraception, maternal health care, post-natal care, voluntary counselling and testing, post abortion care, and STI/HIV/AIDS care. This is in addition for support for the prevention and protection of harmful traditional practices such as female genital mutilation.

Information will also be provided to adolescents concerning sex, sexuality and life skills, drug and substance abuse, supportive organizations, the rights of adolescents, and proper nutrition and hygiene. Services will be delivered by various groups, including schools, religious and community centers, youth and adolescent clubs, youth council meeting places, health units, and through community outreach.

6

THE STATE OF REPRODUCTIVE HEALTH IN UGANDA

Daily Monitor, Tuesday, September 20 2011

Mbale doctors held over death of woman in labour

By David Mafabi
Police have arrested and detained six medical officers of Mbale Referral Hospital as it commenced an investigation into the death of a pregnant teacher and her baby two weeks ago.

Cecilia Nambozo, the deceased, a teacher at Busamaga Primary School in Mbale Municipality, bled to death allegedly unattended to after failing to raise Shs300,000 the medical officers had reportedly asked for.

...

6.1 High rates of maternal and infant mortality and morbidity

Uganda's performance in the area of reproductive health can in the first place be judged by the state of maternal care. Uganda still has a high maternal mortality ratio, at 435 maternal deaths per 100,000 live births. This ratio is still high when looked at from the perspective the country's Millennium Development Goals (MDGs) commitments of reducing maternal mortality to 132 deaths per 100,000 live births by 2015. Uganda has indeed indicated that it is unlikely to achieve this target.

To compound the problem, it has been observed that for every maternal death in Uganda, six women suffer severe morbidities— anaemia, infertility, pelvic pain, incontinence and obstetric fistulas—that lead to chronic and debilitating ill health (Center for Reproductive Health and FIDA Uganda, 2011). It has been demonstrated that these devastating morbidities are caused in part by the majority of deliveries occurring outside of health facilities and without professional attendants.

Evidence of the poor state of maternal health is seen every now and again in media reports, yet these reported cases could be the tip of the iceberg. Many mothers are dying in the hands of medical personnel due to negligence and lack of essential medicines and other logistics for normal and emergency services. Other cases have involved death of expectant mothers who receive no medical attention after failing to pay bribes and other irregular payments to health workers.

6.2 Underfunding of reproductive health

The lack of government commitment to improve maternal health and avoid preventable deaths is among others manifested in the inadequate budgetary allocations to the sector. The government has admitted that there remains an unmet national need for reproductive health supplies estimated at over US\$3.3 million, which represents the largest single unmet need for medicines and supplies in the 2010/2011 budget (Ministry of Health, *Health Sector Budget Framework 2010/2011*).

The lack of operating theatres and skilled obstetricians in many parts of the Uganda has left dead many women in urgent need of emergency obstetrics. In some cases women have died between home and hospital or while on referral between health centre and referral hospital. This has among others resulted from the lack of ambulances in many parts of the country, in addition to the poor state of roads. In some cases labouring mothers have to be transported over long distances either on motorcycles or bicycles on potholed roads.



A bicycle ambulance in Katakwi, Uganda

Source: *Cycling out of poverty* <http://cyclingoutofpoverty.com>

New Vision, 4 October 2001

Every woman and child counts

Dr. Romano Byaruhanga IN Uganda, about 4,000 women die from pregnancy and childbirth related complications every year. The causes of most maternal deaths include severe bleeding before and after delivery, infections, unsafe abortion, hypertensive disorder (eclampsia) and obstructed labour

...
Most deaths are preventable, and are influenced by a complex interaction of social-economic, cultural, physical environment, health seeking behaviours and quality of health delivery services.

...
In many instance, audits done at health facilities have found multiple health system failures like lack of essential supplies for basic or comprehensive emergency obstetric care, lack of blood, an essential component; especially when dealing with bleeding problems, human resource deficiencies with large ratio of patient to one health workers, lack of theatre space to perform timely appropriate lifesaving interventions and poor care by health providers.

...

Official statistics in Uganda shows that over three-quarters of women in Uganda do not receive any form of PPC and that only 11 percent of mothers receive PPC in the first few hours of birth and only 23 percent receive PPC in the first two days of birth (UBOS, 2006).

6.3 Low access to reproductive health services

The poor state of maternal care is also reflected in the poor state of post-partum care (PPC). The World Health Organisation (WHO) has defined PPC as the management of care for mother and infant up to 42 days after delivery (WHO, undated).

Access to family planning services is also poor, which leads to many cases of unintended and/or unwanted pregnancies. In some cases women with unwanted pregnancies resort to unsafe and crude methods of terminating a pregnancy. Unsafe abortion has resulted in numerous health complications and deaths of especially young, unmarried women.

CONSTITUTIONAL PETITION NO. 16

Constitutional Petition 16 of 2011 is a story of two women, Sylvia Nalubowa who died in Mityana Hospital on 19th August 2009 and Jennifer Anguko who died in Arua Hospital on 10th December 2010.

7.1 The case of Sylvia Nalubowa

On 19th August 2009, Sylvia Nalubowa delivered a baby at Manyi Health Centre III, a government health care facility in Mityana. It was, then established that she was to have twins and required emergency obstetric care to deliver the second baby. The mother was referred to Mityana Hospital. Unfortunately, instead of leaving the hospital with the babies, Ms. Nalubowa was wheeled out in a coffin, together with one of the babies. At the hospital, the attendant to the mother, now an emergency case, was first asked to pay for three bottles of rehydrating water, which she did, even when the facility was a government one.

In the words of the attendant, Rhoda Kukkiriza, “at this time the deceased was in extreme pain and crying for help. I went where she was and whatever came out of her was blood and I had no way to help her.” Rhoda Kukkiriza adds that in pain Nalubowa “pledged her *kibanja* [squatter piece of land], hens and pigs if the nurses had helped her out”. These pledges did not however help, Sylvia Nalubowa bled to death, one of the twin babies still in her womb.

The spine-chilling stories of Sylvia Nalubowa and Jennifer Anguko, both of whom are deceased, mirror what Ugandan women in their hundreds, possibly thousands, go through as they exercise their God-given responsibility of bringing life to the world.

Characteristic of many government health facilities, the attendant was immediately asked to pay the midwives UGX 50,000 (about US \$20) before they could attend to the now heavily bleeding mother.

7.2 The case of Jennifer Anguko

Jennifer's husband was asked to pay for medical commodities including a delivery kit – commodities which by government policy should be provided by the hospital free of charge.

More than 300km away and just over a year later and on human rights day, 10th December 2010, Jennifer Anguko checked into Arua Hospital, a regional referral government facility. Time check, 8:30 am. Jennifer, like Sylvia, hoped to go home with a baby, but the events of the day had something else in store for her. Medical staff did not attend to her until over 10 hours later and only when she was gasping her last breath of life.

Jennifer's husband, Valente Inziku, who was at the hospital narrates how the midwives went on chatting and how they even rebuked him for interrupting their conversation when he went to plead with them after over 8 hours of waiting.

7.3 The crux of Constitutional Petition No.16 of 2011

It is the tragic stories of Sylvia and Jennifer from which Constitutional Petition No. 16 of 2011 arises. In the petition, CEHURD and others state that the non-provision of basic indispensable health maternal commodities in government health facilities and the imprudent and unethical behaviour of health workers towards expectant mothers are inconsistent with the Constitution and a violation of the right to health.

The petition attributes the rampant maternal and infant mortality to the manner in which hospitals and medical staff in the country are managed

Rampant maternal mortality is also caused by the government's non-provision of the basic minimum maternal health care packages, which constitutes a violation of the right to health. Furthermore, the petition attributes the high maternal and infant mortality rate to the inadequate human resource for maternal health specifically midwives and doctors, frequent stock-outs of essential drugs for maternal health and lack of Emergency Obstetric Care (EmOC) Services at HC III, IV and hospitals.

It is indicated that the inadequate financial and human resources, capital investment and management issues have resulted in the public sector being unable to fulfil its mandate of providing medicines and other essential maternal health commodities to meet the requirements of universal access to health care.

The petitioners rely on a number of provisions of the law to make their case. This includes Objectives I (i), XIV (b), XXVIII (b), Articles 33(2) & (3), 20(1) & (2), 22(1) & (2), 24, 34(1), 44(a), 287, 8A and 45 of the constitution, provisions illustrated above. This is in addition to the provisions of the international treaties which Uganda has ratified, including the ICESCR, CEDAW and the ACHPR.

7.4 The State's position

In a manner characteristic of state responses, the state makes blanket denials, describing the Petition as speculative. The state also makes reference to the fact there are other competing fundamental rights which the state has to make provision for from its meagre resources. The applicability of the international provisions on which the Petition relies is also rejected on the basis that the state has not made yet made these instruments part of its domestic laws.

The state's response: "The allegations regarding the supposed unethical standards of health workers ... can only be handed by the Disciplinary Committee of the Nurses of Midwives Council and the Disciplinary Committee of the Medical and Practitioners [Council]"

7.5 Key issues in Constitutional Petition No.16 of 2011

Generally, the parties have agreed that the following are the legal issues which the Court should resolve:

- (1) Is the right to the highest attainable standard of health a constitutionally protected right in Uganda?
- (2) Does the non-provision of basic maternal healthcare services in health facilities contravene Article 8A, Objective XIV and XX of the Constitution?
- (3) Does the government's non-provision of the basic maternal healthcare packages in government hospitals resulting into death of expectant mothers and their children a violation of Article 22 of the Constitution?
- (4) Does health workers' and government's failure to attend to expectant mothers subject them to inhuman and degrading treatment, thereby contravening Articles 24 and 44(a) of the Constitution?
- (5) Do the high rates of maternal mortality in Uganda contravene Article 33(1), (2) and (3) of the Constitution?
- (6) Are the families of mothers who have died because of government failure to provide the basic maternal health care packages and non-attendance of health workers in government hospitals entitled to compensation?

COMPARATIVE EXPERIENCES IN LITIGATING THE RIGHT TO HEALTH

The right to health has been the subject of litigation before various international and domestic tribunals. This litigation is important because it proves the existence of the right and the fact that the same can be given judicial enforcement. This section outlines selected constitutional cases that have been adjudicated and the approaches used.

8.1 CEDAW Committee rules against Brazil for delayed service

The most recent decision from an international monitoring mechanism came from the CEDAW Committee in the case, *Maria de Lourdes da Silva vs Brazil* delivered in July 2011. In the case, the petitioner's daughter had been medically induced to push out a premature dead foetus, an operation which came with serious morbidity resulting into her death. While in comma, the deceased had waited for over 8 hours for an ambulance to transport her to a referral hospital. And at the referral hospital, the deceased had been put in a makeshift structure because of the lack of free beds and did not get attention for a long time because her medical records could not be retrieved from a health centre.

The petitioner argued that the death had resulted in violation of the right not to be discriminated against, manifested in the failure to secure safety during pregnancy and child birth of the deceased. This argument was supplemented by another based on Article 12 of CEDAW, which requires states to take all appropriate measures to eliminate discrimination against

The CEDAW Committee rejected the state's argument that it was not responsible for action of the private health centre to which the deceased was first admitted, noting that the State is directly responsible for the action of private institutions when it outsources its medical services, and that it has the duty to regulate and monitor private healthcare institutions.

women in the field of health, which includes appropriate services in connection with pregnancy, confinement and the post-natal period.

The petitioner argued that the state failed to secure these services for the deceased, and that that medical staff had failed to detect in good time the death of the foetus, when birth was induced, at which point an immediate operation should have been carried out to remove it. Curettage surgery had been performed only after 14 hours.

The Committee found the state to be in violation of the right to life and health. The conduct constituting the violation was found to include: the failure to detect the death of the foetus; carrying out curettage surgery a whole 14 hours after induction, at a health centre that did not have equipment; late transfer to a referral hospital; and failure to attend to her at the referral hospital where she waited in a makeshift area for 21 hours until she died.

While referring to its General Recommendation No. 28 (2010), the Committee noted that the lack of appropriate maternal health services in the State Party that fails to meet the specific, distinctive health needs and interests of women not only constitutes a violation of Article 12(2) but also discrimination under Article 12(1). In the opinion of the Committee, this is because the lack of appropriate maternal health services has a differential impact on the right to life of women.

8.2 Indian High Court finds state government in violation of the right to life

In the case *S.K. Garg vs. State of U.P.* of 1998, the High Court of Allahabad received a constitutional petition raising concerns about the pitiable nature of services in public hospitals in Allahabad. The Petitioner complained about the inadequacy of blood banks, worn down X- ray equipment, unavailability of essential drugs and unhygienic conditions at health facilities in the area.

According to the Court, it was indeed true that most of the government hospitals in Allahabad were in a very bad shape and need drastic improvement so that the public is given proper medical treatment. The court took note of the distressing sanitary and hygienic conditions in government hospitals in Allahabad, where poor people are particularly not properly attended to. This was found to be a violation of the right to life.

8.3 Failure to provide emergency care in India is violation of the right to life

In the case *Paschim Banga Khet Mazdoor Samiti vs. State of W.B.* of 1996, a petition was lodged to the Supreme Court after the petitioner was denied treatment at various government hospitals for non-availability of beds after brain haemorrhage in a fall from a moving train. The Petitioner had to go to a private health facility where he expended huge sums of money to get treatment.

The Court requested observed that providing adequate medical facilities is an essential part of the obligation undertaken by the State in a welfare state.

The Court held that the right to health is a part of the right to life, guaranteed by Article 21 of the Constitution of India.

The Supreme Court of India found that failure to provide the petitioner emergency medical treatment infringed his right to life.

In South Africa the Constitutional Court ruled against the provision of the HIV drugs to a few places the government described as pilot sites, thereby denying a greater majority of people outside these sites access to this life saving medication.

In giving meaning to the right, the Court in Peruvia held that health involves the joy of normal functional development of our body.

8.4 Piloting HIV prevention is unreasonable in South Africa

In South Africa, the Constitutional Court *Minister of Health and Others v Treatment Action Campaign* of 2002 condemned as unreasonable a government programme for the provision of Neviripine, a drug that prevented mother-to-child transmission of HIV.

8.5 Brazilian court upholds the right to HIV treatment

In the case of *Azanca Alheli Meza García Expte* of 2003, brought before the Constitutional Court of Peruvia, the petitioner sought a court order to be given comprehensive treatment as an HIV/AIDS patient. He demanded for a constant supply of drugs and periodic reviews and tests. The petitioner relied on a constitutional provision that everyone has the right to protection of his health and of the family environment and community.

According to the Court, the Peruvian Constitution recognises the right of individuals to achieve and maintain a state of physical and mental wholeness. The Court further observed that the principle of progressive realisation and expenses does not rule out setting reasonable timelines or the State's obligation to take concrete and permanent actions aimed at implementing public policies. On this basis, the Court found the implementation of the Operational Plan to be unreasonable.

8.6 Colombian constitutional court rules the state has to act urgently

The Constitutional Court of Colombia dealt with the obligation to act progressively, noting that in some cases immediate action is expected. According to the Court, some of the obligations that arise from a fundamental right and that have a programmatic character are to be carried out immediately, either because they require a simple action of the State, which does not require additional resources.

The Court gave the example of the obligation to provide information of their rights to patients before undergoing a medical treatment. In this regard, example is given of the obligation to take appropriate steps to ensure health care for every baby during his or her first year of life as anticipated by the Colombian Constitution.

Colobia:
The Court held that in some cases, despite the need to mobilise resources required, the severity and urgency of the case requires an immediate state action.

9

CONCLUSION: PROSPECTS AND CHALLENGES OF CASE

Uganda's healthcare facilities are in a dire state, and maternal health is one of the most affected services. The incidents leading to Constitutional Petition No. 16 of 2011 are an epitome of a widespread systemic problem. The petition demonstrates that many maternal deaths are preventable if the state takes its human rights obligations seriously.

Reproductive health as a human right is protected by both international and domestic law. It is important that these provisions are enforced and remedies obtained whenever the state is found to be in violation. This is what Constitutional Petition No. 16 seeks to do.

The right to health has been the subject of judicial enforcement in cases across the globe. Even before judgment is handed down, Constitutional Petition No. 16 has already highlighted the systemic violation of the reproductive health rights of women, arising from both unethical neglect and the lack of essential medicines and facilities.

The petition has generated public debate on maternal health and rallied civil society advocates behind the cause of reproductive health. Although, at this stage one could argue that the case has already made an important impact, the problem of poor maternal healthcare has not gone away yet, and – most importantly – a lot of the maternal deaths are preventable.

It is important to note however that litigation of human rights standards has a number of challenges. First, in situations where the judicial system has a huge case backlog it may

take a long time before the case is disposed off. One has to appreciate and deal with these delays. Secondly, litigation *per se* may not lead to change.

Even when successful, the impact of a case may be limited unless it is followed by deliberate advocacy and lobbying to ensure that the findings in the decision are implemented. As mentioned, these activities will help prepare the ground for implementation of the outcomes of the case and may in some cases induce the desired changes even before judgment is handed down or implemented.

Complementary advocacy activities will generate vital information for use in the case. Lobbying and advocacy can be conducted even when the case is technically lost. Even if the case were to be lost, the cause will definitely be won. The case will also be useful in identifying other areas of human rights warranting litigation, and has built the capacity of various actors to take on litigation as an advocacy strategy.

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CEHURD

CENTER FOR HEALTH, HUMAN RIGHTS AND DEVELOPMENT

Plot 614 Tufnell Drive, Kamwokya

P.O Box 16617 Wandegeya, Kampala

Telephone: +256 414 532283

www.cehurd.org