MEDICAL AND PUBLIC HEALTH IMPLICATIONS OF THE CONSTITUTIONAL PETITION No. 16 of 2011

Center for Health, Human Rights and Development,
Prof Ben Twinomugisha, Rhoda Kukiriza, Inziku Valente

Versus

Attorney General

May 2021

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EXECUTIVE SUMMARY

Uganda's constitution acknowledges that the right to life and the right to health are inherent rights that need to be upheld and protected by the State. In addition, Uganda has ratified several international and regional human rights treaties that guarantee and protect the right to health. The Government of Uganda has also made progress in improving several maternal and newborn indicators reflected in changes in maternal, child and newborn mortality over the past decades however the current mortality rates are still too high. In addition the mortality statistics reveal disparities across wealth quintiles and geographical areas. Improved access to basic maternal health services could therefore result in a dramatic drop in maternal and neonatal mortality.

In addition they can ensure that women do not suffer ill health and psychological torture as a result of pregnancy related complications. In light of the above, CEHURD in 2011 petitioned the constitutional court "Challenging actions and omissions of the Government of Uganda for failure to provide Minimum Maternal Health Services that include non-provision of basic indispensable maternal health facilities, inadequate number of midwives and doctors to provide maternal health services, inadequate budget allocation to the maternal health sector, frequent stock outs of essential drugs, lack of emergency obstetric services at health facilities, non-supervision of public health facilities and the unethical behavouir of health workers towards expectant mothers which is said to have led to the death of women during child birth."

The Petitioners alleged that the actions and omissions were inconsistent with objective 1(i), XIV (b), XV and Articles 33(2) and 3,20(1) and (2),22(1) and (2) ,24,34 (1) ,44(a) , 287,8Aand 45 of the Constitution of the Republic of Uganda.

At the first hearing in 2012 the Respondents raised a preliminary objection to the petition on the basis of the "political question doctrine." The respondents contended

that the petition was framed in a way that required the Constitutional Court to make a judicial decision on political questions. The Constitutional Court upheld the objection and struck out the petition.

Dissatisfied with the decision of the Constitutional Court, the Petitioners filed Constitutional Appeal No.01 of 2013 at the Supreme Court.The appeal was based on the following grounds;

(a). That the learned Justices of the constitutional Court erred in law when they, misapplied the political question doctrine.

(b). That the learned Justices of the Constitutional Court erred in law when they held that the petition did not raise competent questions requiring their interpretation under Article 137 of the Constitution.

(c). That the learned Justices of the Constitutional Court erred in law and misdirected themselves when they decided that the petition called upon them to review and implement the health policies.

The Supreme Court found that the Petition raised competent questions for the Constitutional Court to hear, interpret and determine. The Supreme Court directed the Constitutional Court to proceed and hear the Petition on its merits.

INTERPRETATION OF THE RULING

Justice Barishaki Cheborion delivered the ruling of the learned Judges. Below is an interpretation of the ruling.

The ruling focused on three main areas:

The maternal health services offered in the country.

Maternal health services ensure that women lead a healthy life to their maximum potential without violation of their right to life and right to health. International and National conventions therefore mandate Governments to ensure that women have the required maternal health services. The Court ruled that Government has omitted to adequately provide basic maternal health care services in public health facilities. These deficiencies result in suboptimal delivery of maternal health services including emergency obstetric care services. Access to these services is often worse in more vulnerable populations such as those in rural areas as well as the uneducated.

The Learned Judge declared that

1. The Government's omission to adequately provide basic maternal health care services in public health facilities violates the right to health and is inconsistent with and in contravention of Articles 8A, 39 and 45 read together with objectives XIV and XX of the National Objectives and Directive Principles of State policy of the Constitution;
2. The Government's omission to adequately provide basic maternal health care services in public health facilities violates the right to life and is inconsistent with and in contravention of Article 22 of the Constitution;
3. The Government's omission to adequately provide basic maternal health care services in public health facilities violates the rights of women and is (in)consistent and contravenes articles 33(1), (2) and (3) of the constitution.

4. The Government's omission to adequately provide emergency obstetric care in public health facilities violates the right to health, life and rights.

5. That the Government's omission to adequately provide emergency obstetric care in public health facilities which results into obstetric injury subjects' women to inhuman and degrading treatment and is inconsistent with and in contravention of Article 24 and 44 (a) of the Constitution

The quality and adequacy of the financial, human and material resources required to provide maternal health services.

Uganda does not have adequate resources to provide maternal health services. These include human resources as well as an adequate supply of drugs, supplies and equipment. Uganda has only 0.4 workers per 1000 population falling far below the 2.5 per 1000 population standard recommended by the World Health Organisation (WHO). This stems from the inadequate government budget for health (6 per cent for 2020/2021) as well as weak supervision and performance management of health workers.

The Learned Judge gave the following directives

- In order to meet the constitutional obligation of the State to uphold the right of women and fulfil their reproductive rights, the Government should in the next financial year prioritise and provide sufficient funds in the national budget for maternal health care

- The Government of Uganda through the Minister responsible for health is directed to ensure that all the staff who provide maternal health care services in Uganda are fully trained and all health centers are equipped within the next two financial years (2020/2021 and 2021/2022)

The effectiveness with which the services are offered looking at the implementation of existing policies and the monitoring of the implementation of these maternal health policies.

The court also noted that there were gaps in the monitoring of implementation of maternal health services. Hence the Ministry of Health(MoH) and the Auditor General were directed to submit reports to the Parliament of Uganda to track progress with implementation of the constitutional court rulings.

- In order to maintain a consistent and deliberate effort to improve the status of maternal health care in Uganda, the Government through the Minister responsible for health is directed to compile and submit to parliament with a copy to this court an audit report on the status of maternal health in Uganda at the end of each of the next two financial years (2020/2021 and 2021/2022).
- The Attorney General submits a report at the end of the financial year 2020/2021 showing progress and implementation of the orders in (h).

In addition the court ordered the government to pay the two aggrieved families who were included in this petition benefits of UGX 70,000,000 as general damages and UGX85,000,000 as exemplary damages.

IMPLICATIONS OF THE RULING

As ordered by the Learned Justices, the Government of Uganda is required to take the following actions that will result in progressive realization of the required actions and better health for women.

Increased funding for maternal health

In compliance with the Court ruling, the State should provide adequate funding for the provision of maternal health services. We therefore recommend that;

- Costing studies be done to estimate optimal resources required for maternal health service delivery.
- MOH should develop a resource allocation plan that indicates how the allocations will be increased progressively.
- The MOH reproductive health division in collaboration with civil society should track and report public and private allocations for maternal health as ordered in the court ruling.

Improved capacity to provide maternal health services

To provide the required maternal health services, the country needs to train and recruit an adequate number of health workers as ordered by the Court. To ensure that health workers are available to provide timely and appropriate maternal health services. Government should:

- Incorporate competence based training that equips trainees with skills required to manage maternal and newborn complications (BEmONC and CEmONC) in pre service training curriculum for doctors, midwives and nurses.

- Assess the health worker gaps in its health facilities and develop a plan for recruiting additional health workers with a special focus on doctors, midwives and anaesthetists.

- Conduct a national needs assessment to identify training needs for the health workers who offer maternal health services every five years.

- Partner with development partners to provide regular relevant competence based in service training to its health workers.

- Ensure districts are providing the required supportive supervision and mentorship to the health facilities as evidenced by their supervision reports.

- Revise the staffing norms for midwives at health center III and IV.

- Develop a well-coordinated and funded network of community health workers who can provide community based reproductive health services.

Resources required for service delivery

To provide the required maternal health services, the necessary resources need to be available. Government through the Ministry of Health and in collaboration with her development partners should therefore undertake the following within the next two financial years in compliance with the constitutional court directives;

- Perform an inventory of equipment required for maternal health service delivery in all (health facilities (public and private) every two years.

- Equip facilities with the basic required equipment required for providing basic EmONC at all HC III and comprehensive EmONC services at health centre IV and hospital level.

- Ensure that all basic supplies are available at all health centre III and above.

- To improve access to blood all health centre IVs and hospitals should have all the facilities required for the provision of blood transfusion services.

- To improve referral all health centre IVs and hospitals should have functional ambulances.

Improving Provider Performance

Action needs to be taken to improve supportive supervision and performance management of health workers to ensure that they have the skills required to offer the required services. MOH and her partners should;

- Revitalise supervision by the MoH district health team and the regional referral hospitals.

- Revitalise the facility quality improvement teams.

- Take disciplinary action against health workers who behave unethically.

- Strengthen the linkage between the community and the health facility through the health unit management committees, so as to provide a space for open dialogue between health workers and the community they serve.

- Revitalise the Reproductive, Maternal, Newborn, child and adolescebt health (RMNCAH) score card as a means of improving performance and accountability.

- Civil society should support the implementation of social accountability initiatives aimed at monitoring the implementation of maternal health services.

- The Ministry of Health and Civil society should together support initiatives geared at raising awareness about the Right to health and the right to life and its implications on access to maternal health services.

SECTION 1:

INTRODUCTION

Whereas the Government of Uganda is commended for the progress made in improving several maternal and newborn indicators reflected in changes in maternal, child and newborn mortality over the past decades, the current mortality rates are still too high. Several developed countries such as Sweden, Netherlands, Italy and Norway have a maternal mortality ratio of five or less per 100,000 live births and yet Uganda has a maternal mortality ratio of 336 per 100,000 live births1.[1]

The causes of maternal mortality in Uganda are largely preventable. According to the Reproductive Maternal Newborn and Child Health Sharpened plan[2], 42 per cent of mortality is due to hemorrhage, 22 per cent due to obstructed or prolonged labor and 11 per cent due to complications of abortion. In addition the mortality statistics reveal disparities across wealth quintiles and geographical areas. Improved access to maternal health services can greatly impact on lowering the high fertility rate, adolescent pregnancy rate and unmet need for family planning which further increase the risk of maternal mortality in the country. In addition they can ensure that women do not suffer ill -health and psychological torture as a result of pregnancy related complications. Failure to provide adequate maternal health services contravenes the right to health and even the right to life when these deficiencies lead to fatal outcomes.

1 Uganda Bureau of Statistics. Uganda Demographic and Health Survey 2016
2 Ministry of Health. A Promise Renewed: Sharpened Reproductive Maternal Newborn Child Plan.

The right to life and the right to health are inherent rights that need to be upheld and protected by the State and not granted by the State. Uganda's Constitution acknowledges this in Article 22 of the Constitution3.[3] In addition, Uganda has ratified several international and regional human rights treaties that guarantee and protect the right to health. It also ratified the Convention on Economic and Social and Cultural Rights (CESCR) on elimination of discrimination against women, the African Charter on the Human and People's Rights on the rights of women in Africa (Maputo protocol) and the African Charter (article 16). Article 287 of the Constitution of Uganda recognises and legitimises the applicability of these treaties in Uganda. The Government therefore has an obligation to guarantee and protect the rights spelt out in these treaties.

In light of the above, CEHURD in 2011 petitioned the constitutional court "*Challenging actions and omissions of the Government of Uganda for failure to provide Minimum Maternal Health Services that include non-provision of basic indispensable maternal health facilities, inadequate number of midwives and doctors to provide maternal health services, inadequate budget allocation to the maternal health sector, frequent sock outs of essential drugs, lack of emergency obstetric services at health facilities, non-supervision of public health facilities and the unethical behavior of health workers towards expectant mothers which is said to have led to the death of women during child birth.*[4]"

At the first hearing in 2012 the Principal State Attorney raised a preliminary objection to the petition on the basis of the "political question debate." The constitutional court upheld the objection and struck out the petition on two grounds. Firstly that the petition did not disclose competent questions that required interpretation of the constitution and secondly that the court could not look into the acts and omissions brought forth by the petitioners against the government because of the political question doctrine.[4]

3 Constitution of the Republic of Uganda 1995.

4 Constitutional petition N0 16 of 2011. Center for Health, Human Rights and Development (CEHURD) , Prof Ben Twinomugisha, Rhoda Kukiriza,Inziku Valente versus Attorney General

Dissatisfied with the decision of the Constitutional Court, the Petitioners filed Constitutional Appeal No.01 of 2013 at the Supreme Court. The appeal was based on the following grounds;

(a). That the learned Justices of the constitutional Court erred in law when they, misapplied the political question doctrine.

(b). That the learned Justices of the Constitutional Court erred in law when they held that the petition did not raise competent questions requiring their interpretation under Article 137 of the Constitution.

(c). That the learned Justices of the Constitutional Court erred in law and misdirected themselves when they decided that the petition called upon them to review and implement the health policies.

The Supreme Court found that the Petition raised competent questions for the Constitutional Court to hear, interpret and determine. The Supreme Court directed the Constitutional Court to proceed and hear the Petition on its merits.

Issues for Determination

Justice Barishaki Cheborion delivered the ruling of the learned Judges and the issues listed below where adopted for determination.[5]

1. Whether Government's omission to adequately provide basic maternal health care services in public health facilities violates the right to health and is inconsistent with and in contravention of Articles 8A, 39 and 45 read together with objectives XIV and XX of the National Objectives and Directive Principles of State policy of the Constitution;
2. Whether the Government's omission to adequately provide basic maternal health care services in public health facilities violates the right to life and is inconsistent with and in contravention of Article 22 of the Constitution;
3. Whether the government's omission to adequately provide basic maternal health care services in public health facilities violates the rights of women and is (in)consistent and contravenes articles 33(1), (2) and (3) of the constitution;
4. Whether the Government's omission to adequately provide emergency obstetric care in public health facilities violates the right to health, life and rights to women and is inconsistent and in contravention of article 8 (A), 22, 33 (1) (2) and (3), 45, 287 read together with objectives XIV and XX of the Constitution;
5. That the Government's omission to adequately provide emergency obstetric care in public health facilities which results into obstetric injury subjects' women to inhuman and degrading treatment and is inconsistent with and in contravention of Article 24 and 44 (a) of the Constitution;
6. What remedies are available to the parties?

5 Constitutional Petition No 11 of 2012Center for Health, Human Rights and Development (CEHURD) , Prof Ben Twinomugisha, Rhoda Kukiriza,Inziku Valente versus Attorney General

In the ruling of petition No 16, the Learned Judge made the following declarations and orders.

Declarations of the Constitutional Court

(a). That the government's omission to adequately provide basic maternal health care services in public health facilities violates the right to health and is inconsistent with and in contravention of Articles 8A, 39 and 45 read together with objectives XIV and XX of the National Objectives and Directive Principles of State policy of the Constitution

(b). That the government's omission to adequately provide basic maternal health care services in public health facilities violates the right to health and is inconsistent with and in contravention of Articles 8A, 39 and 45 read together with objectives XIV and XX of the National Objectives and Directive Principles of State policy of the Constitution;

(c). That the government's omission to adequately provide basic maternal health care services in public health facilities violates the right to life and is inconsistent with and in contravention of Article 22 of the Constitution;

(d). That the government's omission to adequately provide basic maternal health care services in public health facilities violates the rights of women and is (in)consistent and contravenes articles 33(1), (2) and (3) of the constitution.

(e). That the government's omission to adequately provide emergency obstetric care in public health facilities violates the right to health, life and rights to women and is inconsistent and in contravention of article 8 (A), 22, 33 (1) (2) and (3), 45, 287 read together with objectives XIV and XX of the Constitution

Orders and Directives of the Constitutional Court

(a). In order to meet the constitutional obligation of the State to uphold the right of women and fulfil their reproductive rights, the government should in the next financial year prioritise and provide sufficient funds in the national budget for maternal health care.

(b). The Government of Uganda through the Minister responsible for health is directed to ensure that all the staff who provide maternal health care services in Uganda are fully trained and all health centers are equipped within the next 2 financial years (2020/2021 and 2021/2022).

(c). The 3rd and 4th petitioners are awarded UGX 70,000,000 each as general damages for the psychological torture and violation of the rights to life, health and cruel and degrading treatment of their loved ones.

(d). The 3rd and 4th petitioners are each awarded as exemplary damages UGX 85,000,000 for the loss of their loved ones as a result of acts and omissions of the medical personnel at Mityana hospital and Arua regional referral hospital.

(e). e) In order to maintain a consistent and deliberate effort to improve the status of maternal health care in Uganda, the Government through the Minister responsible for health is directed to compile and submit to parliament with a copy to this court an audit report on the status of maternal health in Uganda at the end of each of the next two financial years (2020/2021 and 2021/2022).

(f). The Attorney General submits a report at the end of the financial year 2020/2021 showing progress and implementation of the orders in (e).

SECTION 2:

MEDICAL AND PUBLIC HEALTH INTERPRETATIONS OF THE RULING

In considering the remedies available to the parties, the Learned Judge considered the following;

- The right to health, human dignity and life of women encompasses access to adequate maternal health care.
- The right to health should be made available and accessible by the State through the formulation of necessary laws and programs.

The ruling impacts on three main areas as expounded in the ensuing section.

- The maternal health services offered in the country.
- The quality and adequacy of the financial, human and material resources required to provide maternal health services.
- The effectiveness with which the services are offered looking at the implementation of existing policies and the monitoring of the implementation of these maternal health policies.

2.1 Provision of Basic Maternal Health Services

Maternal health care services cover a wide range of services that women receive before pregnancy, during pregnancy, delivery and after delivery. They include sexual and reproductive health services, access to family planning, pre and post-natal care, emergency obstetric care and access to information about family planning, adequate nutrition, pregnancy and related danger signs etc.

These services should ensure that women have a healthy reproductive life including adequate nutrition as well as the services that they require while they provide their unique maternal health duties as women. International and National conventions therefore mandate Governments to ensure that women have the required maternal health services so as to ensure that they lead a healthy life to their maximum potential without violation of their right to life and right to health. Failure to provide these services has been equated to degrading and cruel treatment and torture often experienced through both physical and psychological hardships during the pursuit of maternal health care services.

> *"Failure to provide maternal health services violates the right to life and right to health and Governments must therefore ensure that they provide the basic services required by women to ensure that they lead a healthy life to their maximum potential."*

The learned Judge in the Constitutional Petition observed;

> *'' Maternal health has a direct relation to the physical attributes of women and as such their reproductive health forms an integral part of the health of a woman and for this reason, it is considered part and parcel of human rights of women. The right to health of a woman forms part of her right to life, right to equality and right against torture, cruel, degrading and inhuman treatment."*

In line with these international conventions, the Government of Uganda has put in place several measures to increase access to maternal health services. These include policies such as the Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality in Uganda, Reproductive Maternal Newborn and Child Health Sharpened Plan, Clinical treatment protocols as well as numerous sexual and reproductive health strategies.

Many of these policies have only been implemented partially. For example the Roadmap[6] aimed to increase the availability, accessibility and utilisation of quality skilled care during pregnancy, childbirth and the postnatal period at all levels of the health care delivery system. However in 2016 only 70 per cent of women in rural areas delivered in a health facility[7] and by 2018 only 48 per cent(87/186) of HC IVs were able to provide Comprehensive EmONC (including caesarian sections and blood transfusion).[8] Furthermore, whereas the same policy aimed to strengthen family planning information and service provision for women/men/couples who want to space or limit their childbearing thus preventing unwanted and/or untimely pregnancies that increase the risk of maternal death; only 34 per cent of married women in Uganda use modern contraceptives.

The Government of Uganda has several policies that are aimed at increasing access to maternal health services. However many of these policies have not been implemented comprehensively. Consequently, policies that have not been fully implemented cannot lead to the expected progressive realisation of the rights to health.

The Government of Uganda and her development partners have also provided reproductive health commodities including essential medicines and supplies as well as several multi-sectoral collaborations that improve maternal health such as universal primary education, improved road infrastructure and rural electrification to mention but a few. However, despite these attempts, the Court ruled that the Petitioners proved that the Government has omitted to adequately provide basic maternal health care services in public health facilities.

6 Ministry of Health. Road Map For Accelerating the Reduction of Maternal and Neonatal Mortality in Uganda 2007- 2015.
7 Uganda Bureau of Statistics. Uganda Demographic and Health Survey 2016
8 Ministry of Health. Annual Health Sector Performance Report for 2017/2018

Indeed, the Government has failed to provide several services including basic indispensable maternal health facilities, adequate number of midwives, adequate budget allocation to the maternal health sector, adequate essential drugs, adequate EmONC services, ethical and well supervised health workers. These deficiencies result in suboptimal delivery of maternal health services reflected in poor maternal heath related indicators, which are often worse among the more vulnerable populations.

With regard to family planning, a dismal 34 per cent of women in Uganda overall were using modern family planning methods with only 22 per cent of women in rural areas using modern family planning methods compared to 44 per cent of women from the wealthiest quintiles. Subsequently, the total fertility rate *(a summary measure of fertility that estimates the number of children a woman is likely to have during her reproductive life)* in rural areas is 5.9 compared to 4.0 in urban areas. High fertility and low use of family planning predispose women to more frequent pregnancies and hence a higher risk of mortality.

The consequences are also seen in outcomes such as adolescent pregnancies which were more common in uneducated girls (35 per cent) verses those with at least a primary level education, rural based girls (27 per cent) vs urban based girls (19 per cent) and those from the lowest wealth quintiles (34 per cent) compared to those from higher wealth quintiles (15 per cent).[9]

Skilled birth attendance and early postnatal checks are particularly important to women and newborns because the majority of maternal and newborn deaths occur within the first week after delivery.[10] However, while 89 per cent of women in urban areas delivered in a health facility only 70 per cent of women in rural areas delivered in a health facility. Similarly while 67 per cent received postnatal care only 51 per cent in the rural areas did.

9 Uganda Bureau of Statistics. Uganda Demographic and Health Survey 2016

10 Carine Ronsmans, Wendy J Graham, on behalf of The Lancet Maternal Survival Series steering group. Maternal mortality: who, when, where, and why. Lancet 2006; 368: 1189–200

Government has omitted to adequately provide basic maternal health care services in public health facilities. These deficiencies result in suboptimal delivery of maternal health services hence the poor maternal health indicators which are often worse off among more vulnerable populations.

2.2 Provision of Emergency Obstetric and Newborn Care Services (EmONC)

Women in labour require obstetric care services. The term obstetric care services according to the monitoring and emergency obstetric care handbook refers to services required to improve the availability, accessibility, quality and use of services for the treatment of complications that arise during pregnancy and child birth. These services are provided through a set of signal functions that have been categorised into basic EmONC services comprising six signal obstetric functions and three neonatal signal functions while Comprehensive EmONC comprises eight signal functions and four signal neonatal functions.

The basic six EmONC (BEmONC) signal functions include parenteral administration of oxytocin, parenteral administration of anticonvulsants, parenteral administration of antibiotics, performance of assisted deliveries, removal of retained products of conception, and manual removal of retained placenta. With regard to newborns they should be able to provide newborn resuscitation, treatment of neonatal sepsis/ infection; and oxygen support.

The eight Comprehensive EmONC signal functions include the six signal obstetric functions of a BEmONC as well as performing caesarean sections and blood transfusion services while the additional neonatal signal function is management of low birth weight or premature newborns. In line with the UN Secretary General's Global Health Strategy(GSWC), Uganda pledged to ensure that basic EmONC services are available in all health facilities and comprehensive EmONC in 100 per

cent of hospitals (increasing from 50 per cent to 100 per cent) and 50 per cent of Heath centers (increasing from 17 per cent to 50 per cent)11.[11]

The Court held that;

"The government's omission to adequately provide emergency obstetric care in public health facilities violates the right to health, life and rights to women and is inconsistent and in contravention of article 8 (A), 22, 33 (1) (2) and (3), 45, 287 read together with objectives XIV and XX of the Constitution"

The Court also observed that;

"The Government's omission to adequately provide emergency obstetric care in public health facilities which results into obstetric injury subjects' women to inhuman and degrading treatment and is inconsistent with and in contravention of Article 24 and 44 (a) of the Constitution"

The committee on economic, social and cultural rights interprets the right to health as being inclusive of the provision to timely and appropriate health care. According to the Annual Health Sector Performance report for 2017/2018 while 78 per cent (142/186) of health centre IVs could provide caesarean section services only 48 per cent (87/186) of HC IVs were able to provide Comprehensive EmONC (caesarean sections and blood transfusion). Failure to provide basic EmONC services at lower level facilities such as health center IIIs means that some women are not able to receive the services that they require. Whereas some of them turn to traditional birth attendants; others incur high out-of-pocket costs to travel to higher level facilities that are often further away.

The latter if fortunate may receive the services others, however, fail to receive the required services and may end up dying. The two women reported in this Petition

11 Ministry of Health. A Promise Renewed: Sharpened Reproductive Maternal Newborn Child Plan.

for example both died at the hospital, one a district hospital and the other at a regional referral hospital. One of them bled until she died.[12] In 2019, 79 per cent of facilities experienced blood stockouts.[13] In such cases the rights of women, the right to health and in some cases even their right to life are violated.

In Uganda 336 women out of 100,000 live births[14] lose their lives while performing their God given maternal health duties. Whereas one may say that this is an improvement from 506 women per 100,000 live births who died in 2006, in more developed countries such as Sweden less than three women per 100,000 live births lose their lives as a result of birth related complaints.

2.3 Capacity to Provide Maternal and Newborn Health Services

In CEHURD and others vs Nakaseke District Local Government[15] the Court held that failure of the State to attend to a patient due to the absence of the doctor on duty, was a violation of the patients right to medical health care. In this case, the Judge observed that these services are often not available because of gaps in the country's capacity to provide the required services. Specifically gaps with regard to the availability of health facilities, health workers, supplies and equipment.

Availability of Adequately Trained Health Workers

Uganda does not have adequately trained health workers in all the different categories (e.g. doctors, midwives and anesthetists) to attend to women who need maternal health services. In 2019 only 13.7 per cent of qualified health workers were recruited against the annual recruitment plan at national level. Whereas the WHO recommends 2.5 health workers per 1000 population in 2017/2018 Uganda

12 Constitutional Petition No 11 of 2012Center for Health, Human Rights and Development (CEHURD) , Prof Ben Twinomugisha, Rhoda Kukiriza,Inziku Valente versus Attorney General

13 Ministry of Finance Planning and Economic development. National Budget framework Paper 2020/2021 pg77

14 Uganda Bureau of Statistics. Uganda Demographic and Health Survey 2016

15 Civil suit no 111 of 2012 CEHURD and others vs Nakaseke District Local Government

had only 0.4 per 1000 population.[16] Moreover, their distribution within the country is unequitable with urban based hospitals having up to 80 per cent of doctors and 60 per cent of the nurses. Furthermore, the existing health workers also often lack the expertise required to provide quality care to the women who seek maternal health care services. The court ordered government to provide relevant training for all the health workers who provide maternal health services. The Learned Judge Stated;

> "The government of Uganda through the Minister responsible for health is directed to ensure that all the staff who provide maternal health care services in Uganda are fully trained and all health centers are equipped within the next 2 financial years (2020/2021 and 2021/2022)"

Functioning Equipment and Supplies

Overall the quality of care provided in health facilities in Uganda is still suboptimal. In 2019, only 20 per cent of facilities had attained three star quality status (>75) under the health facility quality of care assessment program. Thirty per cent of the sub -counties did not have functional health care IIIs and 25 per cent of hospitals did not have functioning imaging and radiography equipment.[17] In addition, only 20 per cent of medicines and supplies were procured and distributed against the consolidated procurement plan, subsequently about 19 per cent of facilities experienced stock outs of the 41 essential tracer medicines (over the previous three months).[18]

This deplorable State largely arises from shortages in the resources required for service delivery. Indeed these same issues had been raised by the petitioners in their

16 Ministry of Health. Annual Health Sector Performance Report 2017/2018
17 Ministry of Finance Planning and Economic Development. National Budget framework Paper 2020/2021 pg77
18 Ministry of Finance Planning and Economic Development. National Budget framework Paper 2020/2021 pg77

argument before the Constitutional Court. They noted that in 2015, the Ministry of Health reported that only 33 per cent of medical equipment at general hospitals was in good condition and in use while 63 per cent was in need of repair or replacement. Mama kits were out of stock in 67 per cent of regional referral hospitals. In 2016, 25 per cent of country level health care facilities were out of essential medicines for maternal health such as misoprostol, 14 per cent were stocked out of oxytocin and 29 per cent nifedipine.[19]

The learned judge in upholding the petitioners case concluded:

> '' Women suffer a lot due to shortages or short comings in the delivery of maternal health care services caused by stockout of maternal health care packages, drugs and professional negligence."

2.4 Funding

Funding for the available services has also been a problem. Protection of the right to health mandates government and all its other organs and agencies to undertake actions that will ensure that the right to health is not violated. This includes the provision of adequate resources for maternal health. The Court upheld the contention of the petitioners that although there had been an increase in budget allocation, it was neither consistent nor significant. Statistical evidence presented to the Court showed that only 2.1 per cent of the GDP was spent on health care and that government's expenditure on health care fluctuated between 5.3 per cent and 7.3 per cent since 2015 19.

The Petitioners also observed that there was a disparity between what was allocated and released and spent. The Court observed that the unspent budget lines would

19 Constitutional Petition No 11 of 2012Center for Health, Human Rights and Development (CEHURD) , Prof Ben Twinomugisha, Rhoda Kukiriza,Inziku Valente versus Attorney General

make significant contributions to improvement in health care. Regrettably, the Court observed that the shortfall denied the health care sector an opportunity to provide basic maternal health care services and obstetric care services.
The Court ordered that;

> "In order to meet the constitutional obligation of the State to uphold the right of women and fulfil their reproductive rights, the government should in the next financial year prioritise and provide sufficient funds in the national budget for maternal health care."

Once these funds are allocated and released, it is important that the relevant stakeholders monitor implementation to ensure 100 per cent spending of released funds.

2.5 Maternal Health Status in Uganda

Uganda was able to meet the Millennium Development Goal (MDG) target on promoting gender equality and empowering women, however it was unable to meet MDG five that focused on reducing maternal mortality by two thirds.[20] Although the country has registered a steady decline in maternal mortality which was as high as 527 per 100,000 live births in 2000 compared to 336 per 100,000 live births in 2016 the ratio is still too high. The common causes of maternal mortality which are haemorrhage, obstructed labour, hypertensive disorders etc. have also largely remained unchanged implying that the causative factors have still remained the same. Indeed according to the Annual Health Sector Performance Report number of maternal deaths reported through the MoH Health Management Iinformation System remained above 1000 between 2013/2014 and 2017/2018 (1,147 maternal deaths in 2013/2014 and 1,111 maternal deaths in 2017/2018)21.[21]

20 Ministry Of Health. A Promise Renewed: Sharpened Reproductive Maternal Newborn Child Plan
21 Ministry of Health. Annual Health Sector Performance Report 2017/2018

The deaths are also often highest in the regional referral hospitals highlighting inaccessibility to appropriate care in the lower level facilities. This scenario implies that the vulnerable women who are unable to access services are still dying despite the interventions that are currently in place. High out-of-pocket expenditure further constrains their access to maternal health services in the face of poorly stocked facilities and long distances to health facilities. Maternal health is an integral part of the health of women and of their right to health. Failure to access lifesaving interventions subjects women to degrading and cruel treatment which also amounts to torture.[22] Although Uganda has several policies related to maternal health these policies have not been implemented fully hence the women have not realised the benefits there in. The poor maternal health status of the country is also noted in indices such as the high total fertility rate of 5.4 and the high adolescent pregnancy rate of 24 per cent.[23] The court ordered that;

"In order to maintain a consistent and deliberate effort to improve the status of maternal health care in Uganda, the government through the minister responsible for health is directed to compile and submit to parliament with a copy to this court an audit report on the status of maternal health in Uganda at the end of each of the next two financial years (2020/2021 and 2021/2022)."

The court further Stated that

"The Attorney General is directed to submit a report at the end of the financial year 2020/2021 showing progress and implementation of the orders there in."

22 Constitutional Petition No 11 of 2012Center for Health, Human Rights and Development (CEHURD) , Prof Ben Twinomugisha, Rhoda Kukiriza,Inziku Valente versus Attorney General

23 Uganda Bureau of Statistics. Uganda Demographic and Health Survey 2016

SECTION 3:

IMPLICATIONS OF THE RULING FOR MATERNAL HEALTH

The State needs to take actions that will result in progressive realisation of the required actions and better health for women. This implies that the State must have reasonable and measurable plans with set achievable benchmarks and timeframes for achieving the required outputs, while taking into consideration existing resources. Such actions need to be "reasonable" implying that they need to take into consideration the needs of the vulnerable and the marginalized and those whose "ability to enjoy the right to life are most in peril".

According to the Reproductive Maternal Newborn and Child Health Sharpened plan, maternal mortality statistics reveal disparities across wealth quintiles and geographical areas. Those who are most in need are often the ones who receive the least services. Indeed statistics in Uganda indicate that women in rural areas often utilise less maternal health care services for example with respect to family planning, delivery care and postnatal care. While 89 per cent of women in urban areas delivered in a health facility only 70 per cent of women in rural areas delivered in a health facility.

Similarly while 67 per cent of women in urban areas received postnatal care only 51 per cent in the rural areas did. Access to family planning services is not adequate and yet it reduces the risk of unwanted pregnancies that often contribute to the Country's high maternal mortality. Twenty eight percent of married women had an unmet need for family planning , while 32 per cent of unmarried sexually active women had an unmet need for family planning (Women who are capable of bearing children and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child). Needless

to say, improvements in maternal mortality and access to safe delivery services will also impact neonatal mortality (27 per 1000), which is the single greatest contributor to Uganda's infant mortality (43 per 1000).[24] The subsequent section lays out actions that should be taken in response to the constitutional ruling.

3.1 Increased Funding for Maternal Health

In 2020/2021 the Government allocated UGX 2.7 Trillion shillings to health this is about 2 per cent of its GDP and 6 per cent of its National budget18 and reflects a decline from 8.9 per cent in 2019/2020. According to the sharpened plan 74 per cent of the funding for reproductive health was from households, 17 per cent from non government organisations and only 6 per cent from Government. This highlights the dismal contribution of Government to maternal health and the high burden that households incur in funding reproductive health care services.

Whereas it is noted that the State has resource constraints, the State should consider the basic needs of its people and prioritise actions that could lead to life or death over other actions that may not have similar consequences hence it should prioritise maternal health and allocate adequate funding for it. This is in agreement with the national objectives and directive principles of State policy (OBJ XV and XX) and article 8A of the Constitution, which State that Uganda shall be governed based on principles of national interest and common good.

Furthermore studies have shown that citizens also recommend that the State provides more money for health compared to other sectors.[25] If the State is to provide adequate resources for maternal health it needs to broaden its revenue base so as to generate more resources in addition to prioritising what it has and using it effectively and efficiently. General recommendation 24 under the Convention on Elimination of all Kinds of Discrimination Against Women (CEDAW) also notes that government is mandated to allocate adequate resources to ensure women's

24 Uganda Bureau of Statistics. Uganda Demographic and Health Survey 2016

25 Tatenda T. Yemeke , Elizabeth E. Kiracho , Rebecca R. Apolot Aloysius Mutebi , Rebecca R. Apolot, Anthony Ssebagereka, Daniel R. Evans , Sachiko Ozawa . Health versus other sectors: Multisectoral resource allocation preferences in Mukono district, Uganda. July 2020 PLoS ONE 15(7):e0235250.

right to safe motherhood and EmONC. The actual amount that is adequate may however require further costing studies. So that going forward State allocations are monitored against what is planned.

In compliance with the court ruling, the State should therefore provide adequate funding for the provision of maternal health services. We therefore recommend that;

- **Costing studies be done to estimate optimal resources** required for maternal health service delivery. Meanwhile existing estimates can guide resource allocation. According to the WHO at least 25 per cent - 30 per cent of the health care budget should be allocated to sexual and reproductive health services (WHO). The Reproductive Maternal Newborn and Child Health Sharpened plan was projected to cost USD 682 Million in 2013. This cost excluded other health system investments such as infrastructure and human resource.

- **MoH should develop a resource allocation plan** that indicates how the allocations will be increased progressively.

- **The MoH reproductive health division in collaboration with civil society should track and report** public and private allocations for maternal health as ordered in the court ruling.

3.2 Improved Capacity to Provide Maternal Health Services

To provide the required maternal health services, the country needs to train and recruit an adequate number of health workers as ordered by the court. These health workers should have access to in service training coupled with relevant supportive supervision, mentorship and performance management to ensure that they have the skills necessary to provide the required maternal services.

Health workforce availability

To ensure that health workers are available to provide timely and appropriate maternal health services. Government should:

- **Incorporate competence based training** that equips trainees with skills required to manage maternal and newborn complications (BEmONC& CEmONC) in pre service training curriculum for doctors, midwives and nurses.
- **Asses the health worker gaps** in its health facilities and develop a plan for recruiting additional health workers with a special focus on doctors midwives and anesthetists.
- **Conduct a national needs assessment** to identify training needs for the health workers who offer maternal health services every five years.
- **Partner with development partners to provide regular relevant competence based in -Service training** to its health workers. This could be done through health platforms provided by development partners. This training should incorporate current E health technology in an attempt to reduce costs and increase access to the training.
- **Ensure districts are providing the required supportive supervision** and mentorship to the health facilities as evidenced by their supervision reports.
- **Revise the staffing norms for midwives** at health center III and IV. Currently they are expected to have only two and three midwives, and no consideration is given to the workload in different facilities.
- **Develop a well-coordinated and funded network of community Health workers** who can provide services such as family planning in addition to doing home visits to increase access to information about maternal health services and newborn care.

Resources required for service delivery

To provide the required maternal health services, the necessary resources need to be available. Government through the MOH should therefore undertake the following within the next two financial years in compliance with the directives of the Constitutional Court;

- **Perform an inventory of equipment** required for maternal health service delivery in all (health facilities (public and private) every two years.

- **Equip facilities with the basic required equipment** required for providing basic EmONC at all HC III and comprehensive EmONC services at HC IV and hospital level.

- **Ensure that all basic supplies are available** at all HC III and above. These supplies should include blood, mama kits, and drugs including oxytocin injection (for preventing post-partum heammorage), magnesium sulphate (for managing eclampsia and pre-eclampsia – hypertensive disorders), misoprostol (for managing post-partum hemorrhage), family planning commodities (short term and long term family planning including those for emergency contraception), antenatal corticosteroids (for managing preterm labor), injectable antibiotics (for managing neonatal sepsis).

- **To improve access to blood** all HC IVs and hospitals should have all the facilities required for the provision of blood transfusion services.

- **To improve referral all HC IVs and hospitals** should have functional ambulances.

Improving Provider Performance

Supervision of health workers

Action needs to be taken to improve supportive supervision of health workers to ensure that they have the skills required to offer the required services. This needs to be coupled with quality improvement initiatives. MOH should;

- **Revitalize supervision by the DHT** and the regional referral hospitals. Supervision at facility level has been constrained by the limited resources for facilitating supervision and limited oversight by the regional referral hospitals and the Ministry of health.

- **Revitalize the facility quality improvement teams.** Although facilities appointed quality improvement teams they are not active in most health facilities and yet they are crucial for identifying service delivery bottlenecks and instituting corrective measures.

Unethical behavior of health workers

Two of the deaths that were reported, were partly attributed to negligent and unethical behavior of health workers. Unethical behavior of health workers should not go unpunished. Disciplinary action should be put in place by the respective councils. The following actions should therefore be taken;

- **Establish a user friendly method of reporting negligent actions and omissions** by health workers to the Uganda National Nurses and Midwives Council, Allied Health Professions council and the Uganda Medical and dental practitioners Council.

- **Take disciplinary action** against the said health workers after due investigation and processes.

- **Strengthen the linkage between the community and the health facility** through the health unit management committees, so as to provide a space for open dialogue between health workers and the community they serve. This may facilitate the identification of service delivery challenges including the reporting of unethical behavior and the institution of relevant solutions.

- **Revitalize the RMNCAH score card** as a means of improving performance and accountability. The score card performance should also be discussed in relevant district and regional stakeholder forums (e.g. the extended DHMT).

- **Civil society should support the implementation of social accountability initiatives** aimed at monitoring the implementation of maternal health services.

- **The Ministry of Health and Civil society should together support initiatives geared at raising awareness** about the Right to health and the right to life and its implications on access to maternal health services.

3.3 Monitoring Maternal Health Status

The Convention on Economic social and Cultural Rights (CESCR) requires States to give sufficient recognition to the right to health in national, political and legal systems through legislation and adoption of health policies with detailed plans aimed at realizing the right to health. The Government of Uganda should therefore develop a detailed plan for monitoring the implementation of its maternal health policies. As noted in the National development Plan, Uganda's challenge has been implementation of its policies rather than a lack of the policies. This could also constitute the audit report that is forwarded to the attorney general about the State of maternal health.

The audit report should include the following for purposes of complying with the Constitutional court ruling:

- Skilled attendance at birth (annually).
- Number of women who died and reasons why they died, as well as corrective actions taken based on the maternal death audit reports (Annually).
- Annual funds allocated to maternal health.
- Health workers recruited for maternal health (Annually).
- Number of Facilities that provide comprehensive EmONC (Annually).
- Number of Facilities that provide basic EmONC (Annually).
- Maternal mortality at district level including both facility and community based maternal deaths (Annually).

The following additional indicators could also be provided for purposes of improving the monitoring of the delivery of maternal health services.

- District status report based on the RMNCAH score card.
- Caesarian section rate (Annually).
- Extent of implementation of the sharpened plan for maternal health (Every five years).
- Unmet need for family planning (every five years).

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