

Moses Mulumba (Uganda)
Executive Director, Center for Health, Human Rights and Development (CEHURD)

Testimony for House Committee on Foreign Affairs hearing entitled “Unique Challenges Women Face in Global Health” on February 5, 2020

I appreciate the attention this committee is devoting to global women’s health and I welcome the opportunity to share with you some of the challenges vulnerable communities, notably women and girls, in Uganda face in accessing health care.

For close to 15 years of my professional career, I have been working as a health and human rights advocate. In my current role as Executive Director of Center for Health, Human Rights and Development (CEHURD), a civil society organization based in Kampala, Uganda, my work focuses on ensuring social justice in health systems for the most vulnerable. Our work at CEHURD involves deconstructing health and human rights and use of the law, ground-breaking public interest litigation and policy engagements including evidence-based advocacy and community mobilization as the major entry points that informs our interventions at national level. We focus on issues where there are significant gaps in the right to health, like access to medicines, expanding reproductive and maternal health and rights, including youth-friendly services, and addressing underlying determinants of health including access to a clean and healthy environment, water and sanitation, education, food and housing. We have worked on HIV and AIDS, tuberculosis, gender-based violence, and more. Unsurprisingly, I have witnessed that women, mothers and young girls continue to be the major users of the health system, and this is largely because of the critical maternal function they perform in society. It is hard to believe, but I note that in low income countries, systems have been designed in a way that continues to punish these sisters, wives and friends because of their nature.

My experience with health systems is much longer than my professional life. I grew up in a home with a mother who was a nurse working in private not for profit nursing home, who also had her own small clinic. I have fresh experiences of verbal autopsies and hearing the stories of how women died. I still clearly remember the number of women with babies that flocked both at the health facility and my mum’s clinic. They clearly needed treatment interventions but always had difficulty meeting the bills for care. Back then, as a young boy I did not inquire into the deaths and barriers that women were facing daily. I was not a lawyer and an activist yet!

Even at that time, I remember a number of cases of maternal-related complications at both childbirth and a few days after the delivery. I grew up knowing child delivery as the *‘Lutalo Iwa Bakyala,’* which means the Battle for the Women. Going through child delivery was and still is a matter of life and death. I also remember a number of cases that involved young girls, and, at one time, a married woman that died after an unsafe abortion. Emergency cases of post abortion care after unsafe terminations were common then and continue to be common today. Lack of access to contraceptives, deplorable maternal health services and a highly restrictive legal environment on access to safe abortion services continue to dominate our health system to date.

As a lawyer and a social justice activist now, I keep wondering! Why do women and girls continue to face disproportionate gaps in access to care and rights? Why has the global community not done enough? The global solidarity espoused in compacts like the Sustainable Development Goals are not realized. In Uganda, reproductive rights seem to be an issue for women. We invest less and yet seem to be more interested in controlling the tail end of the consequences (the women’s actions on their bodies) — and this seems to be okay nationally and globally. In Uganda, we still lose sixteen women each day to preventable issues in pregnancy and childbirth. I have witnessed, advocated and litigated cases in which women are struggling to have what would ideally be basics for controlling their bodies from access to kits to support safe deliveries for women and their newborns to the contraceptive method of their choice. From my mother’s practice, I have witnessed the real struggle women, mothers and young girls go through to be empowered to have

information, resources and the courage to access the most basic reproductive rights services. These sisters, wives and friends endure the cost and difficulty of accessing reproductive services in private sector facilities instead of the public health system. How can we ensure that regardless of where a woman enters the health system she receives the quality and acceptable services she deserves?

I note and agree that a population's health and wellbeing is primarily a national responsibility. Every state owes all of its inhabitants a comprehensive package of essential health goods and services under its obligations to respect, protect, and fulfill the human right to health. But at the same time, I know that health is also a global responsibility which creates duties on other states to ensure a safe and healthy world, with particular attention to the needs of the world's poorest people. This particular responsibility on other states is often misunderstood, underrated, abused and lately traded as part of politics. Uganda provides a clear example of the impact donor policies can have on national priorities. As a country, we are dependent on external donor financing for health care. In effect, the United States, one of Uganda's largest providers of global health assistance, is disrupting our national priorities and undermining the progress we have made as a nation.

The recent developments on reinstatement and expansion of the global gag rule demonstrates the consequences of the repressive political decisions from other countries and how these can affect population health and wellbeing in countries like Uganda. The global gag rule wreaked havoc by cutting off funding for much needed health services, especially amongst communities that are already underserved. Such policies like the global gag rule have both direct impacts on the beneficiaries of health services, especially sexual reproductive health care, and other indirect effects like undermining coalitions and other organized groups seeking to support the development of progressive sexual reproductive health and rights policies and services.

As a result of the global gag rule, my organisation has lost key advocacy sub-grants. For instance, we had to close down our work halfway into a four-year USAID-funded project on advocacy for better health, despite progress and our good performance on the project. The only reason cited in this project closure was our failure to sign the new addendum (incorporating the global gag rule) when our sub-grant was up for renewal. The closure of the project brought an immediate termination of our advocacy interventions that promoted accountability and follow-up on the supply chain of essential medicines in the country. Under this project, CEHURD led an advocacy and accountability strategy which focused on ensuring the national medical stores properly managed their stock of key medications and supplies, including anti-malarials and HIV testing kits. The goal for our work was to avoid wasted and expiring stock and ultimately to ensure patients had the medicines they needed at the facilities where they access health care. Internally, the closure also meant immediately terminating the contracts of the key project staff, disruptions of the relationships created with project partners, and distorted our coalition's work with partners involved in accountability work for health systems. The non-clarity of the policy and absence of visible efforts to explain the global gag rule including its scope did not help the situation either. Ultimately, another partner did not take over CEHURD's role in the project at the time of the sub-grant renewal and the project was closed.

It is not an easy choice to comply and keep the funding or refuse and lose access to those resources: jobs and indeed lives are on the line. Nevertheless, for CEHURD, this policy is Incompatible with our mission and work. Our organization promotes social justice and human rights to ensure access to health care for vulnerable communities. We cannot work on one area of health and not others, or prioritize some human rights and not others. This would compromise our mission and values as an institution.

Through my work, I can make the following conclusions. I have witnessed a clear linkage between politics, the law and health outcomes and it's very undeniable that throughout history, political decisions have played a critical role in shaping the development of reproductive rights approaches and indicators for women. Fundamentalism seems to have a continued dominance over women, girls and mothers, especially when it comes to their ability to decide when, if, and how many children to have. We need to operationalize the human rights-based approaches — evidence-based policies and global solidarity should not be ignored as a key factor in health systems strengthening. Maternal and reproductive health should not be a privilege for some, but a right for all. My hope for Uganda and the world is for a future where no woman, mother or young girl dies simply because of their biological composition.