



LITIGATING MATERNAL HEALTH RIGHTS IN UGANDA



what civil society groups must know

September 2013



CEHURD
social justice in health



FOREWORD



THE Center for Health, Human rights and Development (CEHURD) and others filed a land mark Constitutional Petition (Constitutional Petition No.16 of 2011) against the Government of Uganda seeking for declarations on enforcement women’s rights, especially the right to health.

This brief explains the journey towards realizing the right to health in Uganda through the use of litigation, such as in Constitutional Petition No.16 of 2011, as a tool.

“Courting maternal health rights in Uganda” draws lessons from other countries that have not only incorporated the right to health in their Constitutions but also progressed in the realization of this right.

We further outline the relevant laws that can be used to litigate on the right to health, at both the national and international levels, as well a variety of policies that Uganda has all aiming at the realization of sexual and reproductive health rights.

This brief examines the opportunity that Uganda lost in defining the right to health when the Justices of the Constitutional court distanced themselves from determining the Petition when they dismissed the case on the basis of a preliminary objection from the respondents who held that the case raised a political question.

We further highlight a number of advocacy activities that Ugandan CSOs can explore to advocate for the justiciability of the right to health regardless of the outcome of the petition and we hope that they utilize this brief.

We hope this brief will help guide the civil society in conducting legal advocacy on not only maternal health, but also the right to health in general and to contribute to the achievement of social Justice in health in Uganda.

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ABBREVIATIONS & ACRONYMS

AAAQ	Availability, Accessibility, Acceptability and Quality
ACRWC	African Charter on the Rights and Welfare of the African Child
ACHPR	African Charter on Human and Peoples' Rights
ANC	Antenatal Care
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CEHURD	Centre for Health, Human Rights and Development
CESCR	Committee on Economic, Social and Cultural Rights
CRC	Convention on the Rights of the Child
CRPWD	Convention on the Rights of Persons with Disabilities
CRR	Center for Reproductive Rights
CSOs	Civil Society Organizations
EmOC	Emergency Obstetric Care
EQUINET	Regional Network for Equity in Health in East and Southern Africa
HIV	Human Immunodeficiency Virus
HSSIP	Health Sector Strategic and Investment Plan
ICESCR	International Covenant on Economic, Social and Cultural Rights
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
NHP	National Health Policy
NAHP	National Adolescent Health Policy
NDP	National Development Plan
PLHA	Persons Living with HIV/AIDS
PWDs	Persons with Disabilities
RHP	Reproductive Health Policy
TAC	Treatment Action Campaign
UDHR	Universal Declaration of Human Rights
UDHS	Uganda Demographic Health Survey
UHRC	Uganda Human Rights Commission

TABLE OF CONTENTS

EXECUTIVE SUMMARY	2
1. BACKGROUND	5
1.1 Introduction	5
1.2 Objectives	7
1.3 Methods and Scope	8
2. THE LEGAL FRAMEWORK FOR LITIGATING THE RIGHT TO HEALTH	8
2.1 The Right to Health under International Law	8
2.2 The Right to Health in the National Context	12
3. THE POLICY FRAMEWORK: AN OVERVIEW	16
3.1 The National Development Plan (NDP)	16
3.2 The National Health Policy (NHP)	16
3.3 The Health Sector Strategic and Investment Plan (HSSIP)	16
3.4 The National Adolescent Health Policy (NAHP) and Reproductive Health Policy (RHP)	17
3.5 The National Guidelines and Service Standards for Sexual and Reproductive Health and Rights (the Guidelines) 2006	17
4. LITIGATING THE RIGHT TO HEALTH IN UGANDA 18	
4.1 Why Litigation?	18
4.2 Litigating the Right to Health: What can Uganda Learn from South Africa, Kenya and India?	19
5. CONCLUSIONS, EMERGING ISSUES AND RECOMMENDATIONS	27
5.1 Lobby for Legal Reform	28
5.2 Intensify Claims of Health Rights	28
5.3 Monitoring the AAAQ of Health Services	29
6. CONCLUSION	29
REFERENCES	30

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1

BACKGROUND

1.1 INTRODUCTION

ONE of the major achievements in the development of human rights has been the recognition that women’s human rights such as maternal health care are human rights. Indeed, many states, including Uganda have committed themselves to international and regional standards towards the realization of the right to health, including women’s health rights.

Uganda is a party to various human rights instruments, which oblige states parties to realize women’s right to health generally and maternal health rights in particular. These instruments include, the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), the Convention on the Rights of the Child (CRC), the Convention on the Rights of Persons with Disabilities (CRPWD), the African Charter on Human and Peoples’ Rights (ACHPR), the African Charter on the Rights and Welfare of the African Child (ACRWC), and the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (Women’s Protocol).

At the national level, the 1995 Constitution accords women “full and equal dignity of the person with men” (article 33(1)) and obliges the state “to provide the facilities and opportunities necessary to enhance the welfare of women to enable them realize their potential and advancement” (article 33(2)). Women also have a “right to affirmative action to correct the imbalances created by history, tradition and custom”(article 33(5)).

In compliance with its international human rights obligations, Uganda’s health policy framework covers many issues with a bearing on the right to health. The relevant policies include the National Development Plan 2010/11-2014/15 (NDP), National Health Policy 2009 (NHP), the Health Sector Strategic Plan III 2010/11-2014-15 (HSSP III), the Reproductive Health Policy

CONSTITUTION OF UGANDA:

Article 33(1) accords women “full and equal dignity of the person with men”.

Article 33(2) obliges the state “to provide the facilities and opportunities necessary to enhance the welfare of women to enable them realize their potential and advancement”.

(RHP), the National Adolescent Health Policy 2004 and the 2006 National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights.

The policy framework prioritizes key maternal health interventions, including: 1) emergency obstetric care (EmOC), which addresses the major direct causes of maternal mortality and morbidity; 2) skilled attendance at birth, which enables relevant health workers to detect and manage complications or refer pregnant women for further management; 3) family planning, which is aimed at preventing unintended pregnancies; and; 3) antenatal care (ANC), which seeks to prevent and detect pregnancy related complications.

In spite of these legal and policy interventions, maternal health related conditions are still worrying: they contribute 20% of the disease burden. According to the Uganda Demographic and Health Survey (UDHS) 2011, MMR has dropped from 505 to 438 deaths per 100, 000 live births, which is still well above the MGD target of 131/100, 000 live births.¹ The percentage of births attended to by skilled health personnel is as 58%.² The proportion of facilities providing appropriate EmOC is also low with the national unmet need for EmOC at 34.3%.³ In fact, only 11.7% of women deliver in full functional comprehensive EmOC facilities.⁴

Contraceptive Prevalence Rate (CPR) is also low in rural areas at 21% compared to urban areas at 43%. According to the 2011 UDHS Report, only 30% of women in their reproductive age use contraception. Most HC II, III and IV are not providing comprehensive sexual and reproductive

WORRYING MATERNAL HEALTH:

- Maternal conditions contribute 20% to the national disease burden
- Maternal mortality ratio (MMR) estimated at 438 deaths per 100, 000 live births, well above the MGD target of 131 per 100, 000 live births
- Proportion of births attended to by skilled health personnel, 58%
- The national unmet need for EmOC, 34.3%
- Only 11.7% of women deliver in full functional comprehensive EmOC facilities

1 UBOS, Uganda Demographic and Health survey 2011

2 Ibid.

3 Ministry of Health, Health Sector Strategic Investment Plan 2010/11-2014/15.

4 Ibid.

WORRYING

MATERNAL HEALTH:

- Contraceptive Prevalence Rate (CPR): Rural 21%; urban 43%
- Only 30% of women in their reproductive age use contraception
- Unsafe abortion, which is one of the leading causes of maternal mortality and morbidity
- About 300,000 induced abortions take place per year among women aged 15-49
- 55% of the abortions occur in adolescent girls aged 17-20 years
- Abortions occur at a rate of 54 per every 1,000 women
- 1,200 women die each year from unsafe abortions in Uganda

health (SRH) services, especially family planning services. A 2011 study by the Centre for Health, Human Rights and Development (CEHURD), which assessed trends in access to essential reproductive health commodities at public health facilities in Uganda for the period (2006-2010) also reported a low level of demand and uptake of family planning services; lack of consistency in the supply and availability of ANC commodities; and problems with the availability and affordability of EmOC commodities and services in the country (CEHURD, 2011).

There are also reported increased cases of unsafe abortion, which is one of the leading causes of maternal mortality and morbidity in Uganda. There are about 300,000 induced abortions annually amongst women aged 15-49 and 55% of the abortions occur in adolescent girls aged 17-20 years with limited capacity to manage post abortion complications (CRR, 2012).

Abortions occur at a rate of 54 per every 1,000 women and account for about 155 of maternal mortality in the country. Approximately 1,200 women die each year from unsafe abortions in Uganda. This is largely attributed to a restrictive legal framework, which forces women who desire to abort to carry it out underground in unsafe conditions. Consequently, there have been calls for liberalization of the abortion laws in Uganda (CRR, 2012).

Recently, there was an attempt to challenge government's failure to provide basic maternal health care commodities and services, which has led to maternal mortality and morbidity in the country was challenged in court. In *CEHURD & 3 Others v. Attorney General* (Constitutional Petition No. 16 of 2011), the petitioners sought declarations that the non-provision of these commodities violates women's human rights, especially the right to health and the right to life.

However, the Constitutional Court was upheld the respondent's preliminary objection that the petition should be dismissed since it requires the court to make a decision involving political questions.

The filing of the Petition saw development of a loose movement in the name of Coalition to Stop maternal mortality in Uganda which is a composition of many civil society organizations fighting to end the crisis of preventable maternal deaths in the Country. The combination of litigation and Civil society advocacy has brought change in the health service delivery and realization of women's rights to maternal health care.

It is important thus that an outline of litigation information regarding maternal health be given to the Civil society organizations in this movement as an attempt to increase not only their knowledge on litigation maternal health but also emphasizing their engagement in carrying out litigation.

1.2 Study Tasks

The following were the main tasks of the study:

- (a) To analyze the legal and policy frameworks for litigating the right to health in Uganda;
- (b) To advise on the legal procedures and processes for litigating this right, drawing on lessons from other jurisdictions such as South Africa, Kenya and India; and
- (c) To provide a legal opinion on the implications of the ruling in *CEHURD & Others v. Attorney General* (Constitutional Petition No. 16 of 2011) on the right.

CONSTITUTIONAL PETITION NO. 16 OF 2011

CEHURD and three other petitioners sought declarations by the Constitutional Court that the non-provision of emergency obstetric care commodities violates women's human rights, especially the right to health and the right to life.

The Constitutional Court upheld the Attorney General's preliminary objection that the petition should be dismissed arguing that it required the court to make a decision involving political questions.

2

LITIGATING THE RIGHT TO HEALTH IN UGANDA

Violations of human rights generally and the right to health in particular can be challenged through courts, which are the principal organs for the enforcement of law and the protection of human rights. These courts include the Supreme Court of Uganda, the Court of Appeal, which also sits as the Constitutional Court, and the High Court and such subordinate courts as may be established by law (article 129(1)).

Matters involving the interpretation of the Constitution are handled by the Constitutional Court (article 137). The Constitution guarantees judicial independence. This means that the judiciary should not be subjected to any control, interference, direction or influence by any other person including the President, ministers or any other person or authority (article 128).

The Constitution provides that ‘[j]udicial power is derived from the people and shall be exercised by the courts established under this Constitution in the name of the people and in conformity with law and with values, norms and aspirations of the people’ (article 126(1)). It can be argued that this provision promotes judicial activism in the country by empowering the judiciary to expansively interpret human rights provisions in the Constitution in order to promote the most important aspiration of Ugandans: life with dignity.

Besides the Courts are Quasi Judicial bodies that can handle cases of Human rights violations. Such bodies include the Uganda Human Rights Commission, Equal Opportunities Commission, Uganda Dental and Medical Practitioners Council, Nurses and Midwives Council and the Allied Professionals Health council.

2.1 WHAT IS LITIGATION?

Litigation is a process of carrying on a law suit. It involves two or several parties that are separately represented¹. The Court or any quasi judicial body is required to adjudicate on issues brought before it by the litigants and thereby resolve their dispute. The litigation process is usually common in civil law suits. In this process there is the plaintiff [that is the person who brings upon a suit against the defendant] and the defendant [the person against whom the suit is brought].

Litigation can both probono and strategic. Strategic litigation entails Identification of the health rights violations in the communities that affect the public as a whole as well as legislations that have adverse effects or those that threaten the realization of social justice in Health. Under this, cases are chosen strategically to set important precedents, which have an impact beyond the scope of the specific cases and works to improve health and human rights in various areas.

Provision of Probono Legal Services involves Identifying victims of health in the communities. Under this we offer free legal services to those individuals by pursuing their concerns in the Courts of laws. Probono representation looks at increasing access to social justice in health rights, specifically with vulnerable groups, with collaboration between community health advocates, health rights paralegals, and CEHURD lawyers.

2.2 WHY LITIGATION?

One of the ways of challenging violations of human rights is through court action. Courts can advance socio-economic rights such as maternal health care under the right conditions especially where there is minimum state interference. Litigation contributes to the development, interpretation and clarification of the right to health. By framing maternal health issues in the powerful language of rights, the litigation process assists in placing such issues on the agenda, both before the judge and the court of public opinion. Civil Society Organizations (CSOs) and other activists should ensure that the litigation process is adequately publicized through the Internet/social media, electronic and print media so that the public is able to learn about and debate the relevant maternal health issues.

¹ Black's Law Dictionary, Eighth Edition

It should be noted that international law and human rights subjects/courses are optional in many universities. It is most likely that many Ugandan lawyers and judges may not have studied these courses. The court process can thus be a learning process for Ugandan lawyers and judges handling health and human rights issues.

It should also be noted that though litigation is usually costly, and time-consuming, it may result in the state taking appropriate action to pre-empt a court order. Litigation highlights government failures. Any sensible government, which cares about the socio-economic needs of its people, may fear to be embarrassed before the local (electorate) and international community. CSOs may thus find it necessary to pursue a negotiated settlement to avoid a full scale trial. Lawyers handling health rights issues must ensure that they rely on factual/empirical data rather than solely on legal submissions.

It is important to point out that in litigating socio-economic rights issues, real work commences after a litigant has obtained a court order. Litigation should be seen as an integral part of a broader struggle for realization of the right to health generally and maternal health rights in particular. A court victory provides a basis on which further action---whether legal or otherwise---may be based. It lays a foundation for further advocacy, campaign work and litigation. The court decision must be used to press for more substantial changes in the design and implementation of legal, policy and institutional frameworks.

Post decision follow-up by the initial or new claimants is critical in the struggle for the realization of health rights. It is trite that judges have no powers to enforce their own orders; they rely on the executive branch of government. The litigants must therefore actively engage the relevant government officials to ensure that the court order is implemented. However, losing a case should not dissuade CSOs and public spirited individuals from instituting other cases on related but not necessarily similar socio-economic issues. In any case, litigation has its own power: to have the state publicly account for its conduct. It is only through holding the state accountable that the needs of the indigent, vulnerable, disadvantaged and marginalized will be met.

2.3 LITIGATION OPTIONS AVAILABLE TO VICTIMS OF MATERNAL HEALTH RIGHTS VIOLATIONS

The laws set out several options and remedies available to persons who have been subjected to maternal health rights violations.

In Uganda, the Constitution and other laws set out remedies that are available to the victims of maternal health rights violations, their families and any concerned body or organization and these are outlined below.

2.3.1. Enforcement of rights under Article 50 of the Constitution

The Constitution in Article 50 (1) guarantees a right to any person who has a claim that a fundamental or any other right has been infringed or threatened to apply to a Competent Court for redress.

Article 50 is very important insofar as it not only guarantees the individual the right to apply to a

Competent court for redress in cases of violation of such individual's rights but it also empowers other persons or organizations to pursue a case in the interest of another person or group of persons². This is what has been described as a 'busy-body' provision in that it does away with the restrictive rules of locus standi which restricts the legal capacity to sue in court only to an individual/group that can show a direct interest in the matter³.

Furthermore Article 50 is important since it directly operationalizes and enforces the rights and freedoms of the individual or group enshrined in Chapter Four of the Constitution by providing for the right to apply to court in case of any violation or threat to the right.

² Article 50(2) of the Constitution of the Republic of Uganda of 1995

³ Green Watch vs. AG & NEMA Miscellaneous application 140 of 2002 where a preliminary objection was raised to the effect that the plaintiffs had no locus to bring the case before the courts of law taking the position that was stated in the case of Rwanyrare before the case represented a case of human rights violations the representative action that was fronted by the defendants was not applicable in the situation before the applicants need have the same interest as those affected and similarly would bring a case for the violations of rights that the other party did not realize that his rights had been infringed upon. In the courts consideration the two cases were different in nature hence the order sighted by the defendants was not applicable in the situation.

It also empowers Courts to give appropriate redress including awarding compensation for such violations. A party may seek for Court orders such as; declarations, compensation, damages, cost among others. human rights case for enforcement of rights under Article 50 is filed by way of a Plaint in the High court. The Plaint must entail and be supported by the following;

- Specifically highlight that it is a Plaint under Article 50 of the Constitution seeking for declarations of violation of human rights.
- The Plaint is supported by a summary of evidence, list of witnesses, list of documents and list of authorities to be relied on by the party instituting such a case.
- Any documents relating to the violations should be availed to support the claim (These may include medical documents, police documents, photographs, etc)

Where a plaint meets the above requirements, it is filed in the Civil Division Registry of the High Court.

2.3.2 Petition to the Constitution Court

Where any person feels that an Act of Parliament or any other law or anything done under the authority of any law is inconsistent with any provision of the Constitution can petition the Constitutional Court for a declaration to that effect or for any appropriate redress. This is also extended to instances where any act or omission by any person or authority contravenes or is inconsistent with the Constitution⁴.

The Constitutional Court may be petitioned over the violation of the right to health using other rights related to it such as the right to life; right to a clean and healthy environment; right to access information, freedom from cruel, inhuman and degrading treatment; right to education; right to a family; rights of women among others. This can be inferred from other jurisdictions such as South Africa and India where Judges have come up with innovative ways of deriving the right to health for instance the right to life has been expounded on by the Indian jurisprudence to include the right to health.

The Petition has to be clear on the provisions in a given law inconsistent with the Constitution or the acts and omissions leading to the violation of the right to health as

⁴ Article 137 (3) of the Constitution of the Republic of Uganda of 1995

well as highlighting the circumstances surrounding the violation of the right to health. This Petition is supported by Affidavits of the petitioners or any other witness who wishes to support the matter and these may include experts, amicus curies among others.

Where the Petition meets the requirements set by law it is thereby filed in the Constitutional Court Registry. The above procedure is what CEHURD and others followed in filing Constitutional Petition No.16 of 2011.

2.3.3 The Uganda Human Rights Commission

Another forum through which violation of human rights can be challenged is the Uganda Human Rights Commission (UHRC). Under article 52 (1) (a) of the Constitution, the UHRC has powers to investigate, at its own initiative or any particular complaint made by any person or group of persons against the violation of any human right. It may recommend to Parliament effective measures to promote human rights, including provision of compensation to victims of violations of human rights or their families (article 52 (1) (d). The UHRC is also charged with the responsibility of promoting public awareness about human rights and monitor government compliance with international treaty and convention obligations on human rights (article 52 (1) (e).

The question is: how does an aggrieved person access the UHRC? Unlike the courts, whose procedure is complex, accessing the UHRC is easier. An aggrieved person or an organization acting on his/her behalf simply files a complaint with the Commission, which summons the parties and hears it at an appropriate time. Unlike a plaint, which may require a technical person to prepare, a complaint to the UHRC can even take the form of a letter. The staff of the Commission can readily assist a person to register a complaint. The procedure in the Commission is rather informal unlike that in the court, which is formal, technical and adversarial.

2.3.4 Filing Complaints with the Equal Opportunities Commission

The EOC is established by virtue of Article 32 (3) and (4) of the 1995 Constitution of the Republic of Uganda and governed by the Equal Opportunities Commission Act of 2007. It is mandated to eliminate discrimination, inequalities and marginalization in the Country. In a bid to ensure the fulfillment of its mandate, it was entrusted with powers of Court⁵.

5 Section 15 (1) of the EOC Act

Where any act, omission, circumstance, practice, tradition, culture, usage or custom that is found to constitute discrimination, marginalization or which otherwise undermines equal opportunities, the Commission may settle the matter through mediation, conciliation, negotiation, settlement or other dispute resolution mechanism⁶. The Commission may also hear and determine complaints by any person against any action, practice, usage, plan, policy programme, tradition, culture or custom followed by any organ, body, business organization, institution or person which amounts to discrimination, marginalization or undermines equal opportunities⁷.

The Commission is empowered to investigate or inquire into, on its own initiative or 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 constitutes 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 be used to enforce a variety of rights where evidence of discrimination exists. Therefore all acts and omissions relating to discrimination, inequality and marginalization in the health Care setting may be filed in the Commission for redress.

Where a person or a group of persons feel that they have been discriminated or marginalized in any way, such an individual or group of persons can file a complaint with the Commission. The Complaint has to be lodged in writing and signed by the Complainant or complainants⁸.

2.3.5 Filing Complaints with the Medical and Dental Practitioner’s Council

The Medical and Dental Practitioners Council is a body corporate established by the Medical and Dental Practitioners Act Cap 273 with the capacity to sue or be sued in its name. The Council is mandated inter alia to exercise disciplinary control over medical and dental Practitioners⁹.

The Council in fulfilling the above mandate; it is empowered to undertake investigations

6 Section 14 (3) of the EOC Act

7 Section 14 (4) of the EOC Act

8 Section 23(1) of the EOC Act

9 Section 3(d) of the Medical and Dental Practitioners Act Cap 273

into allegations of professional and unethical misconduct of the medical and dental practitioners and award penalties accordingly¹⁰.

The medical and dental practitioners in the conduct of their profession are required to uphold and respect human rights¹¹. Where a medical or dental practitioner through his or her acts or omissions violates human rights of patients, he or she is deemed to have breached the Uganda medical and dental practitioners code of professional ethics and thus subject to inquiry by the Council where the victims file complaints against them.

The Council developed guidelines in order to direct individuals or groups of persons on how to file complaints with the Council when they have been subjected to human rights violations by the medical or dental practitioners¹².

The complaint has to be in writing and signed by the complainant or his or her legal representative or any other person lodging the complaint on behalf of the complainant. The complainant is required to identify the practitioner properly by supplying his or her surname, initials and practice address. The complaint must also be comprehensive containing all the relevant dates, facts relating to the raised allegations and supported by relevant documents where necessary. When the Registrar receives the complaint, he or she may request for further information from the complainant or may take any other action for purposes of verifying the allegations¹³.

10 Section 33 of the Medical and Dental Practitioners Act Cap 273

11 The Uganda medical and dental practitioners code of professional ethics,2008

12 The Guidelines in Respect of Complaints against Medical and Dental Practitioners, 2002

13 *ibid*

2.3.6 Filing Complaints with the Nurses and Midwives Council

The Nurses and Midwives council is a body corporate established by the Nurses and Midwives Act Cap 274 with the capacity to sue and be sued in its own name. ¹⁴The council is mandated inter alia to regulate the conduct of nurses and midwives and to exercise disciplinary control over them.¹⁵

In the course of conducting their duties, the nurses and midwives are governed by a code of professional ethics which inter alia provides that nurses and midwives should work with others to protect and promote the health and wellbeing of those in their care, families and careers, and the wider community¹⁶.

The Nurses and Midwives council established a disciplinary committee that handles matters related to among others professional misconduct of a nurse or a midwife in the course of their professional calling.¹⁷

2.2.7 Filing Complaints with the Allied Professional's Council

The Allied Health Professionals Council is a body corporate established by the Allied health Professional Act Cap 268 with capacity to sue or be sued in its corporate name. The body is mandated among others to regulate the conduct of allied health professionals and to exercise disciplinary control over them¹⁸.

The Act under section 37 establishes a disciplinary committee which is responsible for handling complaints filed against the professionals. Any allegation against any of the allied health professionals is filed with the Council¹⁹.

14 Section 2(1) Nurses and Midwives Act cap 274

15 Section 3(1) (b) *ibid*

16 The code, Standards of Conduct, Performance and Ethics for Nurses and Midwives

17 Section 37 (1) (c) *ibid*

18 Section 4(b) of the Allied Health Professional Act Cap 268

19 Section 38 (1) of the Allied Health Professional Act Cap 268

3

THE LEGAL FRAMEWORK FOR LITIGATING THE RIGHT TO HEALTH

3.1 The Right to Health under International Law

MATERNAL health rights are part of the right to health, which is firmly established under the following international and regional instruments:

3.1.1 The Universal Declaration of Human Rights

The Universal Declaration of Human Rights (UDHR) entitles every human being to an adequate standard of living, including medical care. The declaration demands special care and assistance for motherhood and childhood (article 25(1)). The UDHR is part of customary international law, which is directly applicable to Uganda.

3.1.2 The International Covenant on Economic, Social and Cultural Rights (ICESCR)

The ICESCR obliges the state to protect the right to health. The ICESCR describes it as the right to ‘the highest attainable standard of physical and mental health’ (article 12(1)). The Committee on Economic, Social and Cultural Rights (CESCR), an organ with the responsibility to interpret the ICESCR, has in General Comment No. 14 stressed the right to maternal, child and reproductive health, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources to act on the information. Like the UDHR, the ICESCR calls upon states parties to accord protection to mothers “during a reasonable period before and after child birth” (article 10(1)).

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.

According to General Comment No.14, the right to health contains four critical elements (AAAQ):

- *Availability*: Functioning public health and health care facilities, goods and services as well as programmes in sufficient quantity;
- *Accessibility*: Health facilities, goods and services should be accessible to everyone within the jurisdiction of the state party. Accessibility includes, non-discrimination, physical accessibility (affordability), and information accessibility;
- *Acceptability*: Health facilities, goods and services must be respectful of medical ethics and culturally appropriate, as well as gender and life-cycle sensitive;
- *Quality*: Health facilities, goods and services must be scientifically and medically appropriate and of good quality.

STATE OBLIGATION TO RESPECT THE RIGHT TO HEALTH:

The state is required to refrain from any action or conduct that interferes with existing access to health care, or acts that would make it more difficult for an individual to gain access to care services

Like any other human right, the right to health imposes three major obligations on the state, namely: to respect, protect and fulfill the right. The *obligation to respect* requires the state to refrain from interfering directly or indirectly with the enjoyment of the right to health. Thus, any action or conduct by the state or private person that interferes with existing access to health care services, or would make it more difficult for an individual to gain access to existing health care services, could be a violation of the right to health.

The *obligation to protect* requires the state to take measures that prevent third parties from interfering with the right to health.

The *obligation to fulfill* requires the state to adopt legislative, administrative, budgetary, judicial, promotional or other measures towards the full realization of the right to health. The state is obliged to give sufficient recognition to the right to health in the national, political and legal systems. The state is obliged to *facilitate* (take positive measures that enable and assist) individuals and communities to enjoy the right to health.

The state is further required to *provide* a specific right (e.g. maternal health care), when people are unable, for reasons beyond their control e.g. poverty, to realize that right themselves by the means at their disposal.

The state has a margin of discretion in meeting its obligations: it can *progressively realize* the right to health to the maximum of its available resources. However, this does not mean that the state can simply do nothing. The state has an obligation to move as expeditiously and effectively as possible towards full realization of the right to health. It must not take “retrogressive measures” in relation to the right to health unless they can be justified.

Although health rights are to be progressively realized, there are certain obligations that are of immediate effect. Firstly, there is the obligation to eliminate discrimination against women in all fields including health care.

Thus, failure to remove obstacles to women’s enjoyment of their maternal health rights or take legal or other measures to ensure the enjoyment of the rights is discriminatory and in breach of a state’s obligations. Second, the obligation to take concrete, deliberate steps towards the realization of the right to health.

**STATE OBLIGATION
TO FULFIL THE
RIGHT TO HEALTH:**

The state is required to take measures to enable and assist individuals and communities to realize the right to health

**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.

The right to health contains minimum core obligations that should be achieved by all states irrespective of their economic situation at the earliest possible moment. These obligations are non-derogable and they include:

- 1) to ensure the right of access to health facilities, goods and services without discrimination, especially for vulnerable and marginalized groups;
- 2) access to essential drugs;
- 3) access to critical maternal health care services such as labour and delivery care; and
- 4) access to information.

3.1.3 Convention on the Elimination of all Forms of Discrimination against Women (CEDAW)

The CEDAW specifically provides for the protection of women's human rights, including maternal health rights. CEDAW obliges states parties such as Uganda to take all appropriate measures "to eliminate discrimination against women by any person, organization or enterprise" (article 2(e)) in order to ensure that women are guaranteed access to health care including those related to family planning Article 12(1)).

The states are obliged "to ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary" (article 12(2)). The states should ensure that women in rural areas enjoy the right "to have access to health care facilities, including information, counseling and services" (Article 14).

In General Recommendation No. 24, the CEDAW Committee, which monitors implementation of the CEDAW, affirmed that access to maternal health care is a basic right. The Committee noted that ‘it is the duty of States parties to ensure women’s right to safe motherhood and emergency obstetric services and they should allocate to these services the maximum extent of available resources’.

In *Maria de Lourdes da Silva v. Brazil* (2011), the Committee found Brazil to be in violation of the rights to health and life. In this case, the petitioner’s daughter, who had developed obstetric complications (she was medically induced to push out a dead foetus) had to wait for many hours for an ambulance to transport her to a referral hospital.

Due to a lack of free hospital accommodation and in absence of her medical records from the health centre, the daughter, who was in comma, was put in a make shift structure and did not get immediate medical attention. Surgery was performed on her only 14 hours later. She later died.

The petitioner argued that had the surgery been performed on her daughter immediately she developed complications, she might have survived. The CEDAW Committee found that the state was in violation of the rights to health and life. The Committee was of the view that a state party, which does not cater for women’s distinct and special health needs by availing appropriate maternal health facilities, is in violation of women’s right to health under article 12 of CEDAW.

3.1.4 Convention on the Rights of the Child (CRC)

The CRC specifically 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 (article 24(1)). States are obliged to take appropriate measures to diminish infant and child mortality and to

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;
 - ...

‘ensure proper prenatal and post natal services’ (24(2)). Such measures are certainly aimed at ensuring mother and child survival.

3.1.5 Convention on the Rights of Persons with Disabilities (CRPWD)

The CRPWD guarantees persons with disabilities (PWD) the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability (article 25). In this vein, the convention obliges states parties to provide PWD with free or affordable sexual and reproductive health care goods and services of good quality (article 25(b)).

3.1.6 African Charter on Human and Peoples’ Rights (ACHPR)

At the regional level, the ACHPR guarantees every individual the right to enjoy the best attainable state of physical and mental health (article 16(1)). States parties are obliged to “take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick” (16(2)). States parties are also obliged to ensure the elimination of every discrimination against women as stipulated in international declarations and conventions (art 18(2)).

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.

3.1.7 The African Charter on the Rights and Welfare of the African Child (ACRWC)

The ACRWC guarantees the African child the right to the best attainable standard of physical, mental and spiritual health (article 14(1)). States parties are required to take measures to ensure reduction of infant and child mortality (article 14(2)(a)) and also to ensure ‘appropriate health care for expectant and nursing mothers’ (article 14(2)(f)).

3.1.8 The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women's Rights in Africa (Women's Protocol)

The Women's Protocol is the only treaty that specifically provides for women's human rights from an African perspective. It obliges states parties to ensure respect for and promotion of the 'right to health of women, including sexual and reproductive health' (article 14(1)).

Women's right to health 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; and
- c) the right to choose any method of contraception.

States are obliged to take appropriate measures to 'provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas' (article 14(2) (a) and to 'establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding'(article 14(2) (b).

States shall also take appropriate measures to authorize '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'(article 14 (2) (c)).

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;
 - ...

3.2 RIGHT TO HEALTH: NATIONAL CONTEXT

CONSTITUTION:

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:

“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

THE 1995 Constitution does not explicitly provide for the right to health in the Bill of Rights (Chapter Four). However, through a careful scrutiny of the provisions of the Constitution, it is possible to locate this right and the attendant state obligations to protect the same.

The Constitution contains National Objectives and Directive Principles of State Policy (NODPSP), which are supposed to ‘guide all organs and agencies of the State, all citizens, organizations and other bodies and persons in applying or interpreting the Constitution or any other law and in taking and implementing any policy decisions’ (NODPSP I). Under NODPSP XIV, the state shall endeavour to fulfill the fundamental rights of all Ugandans, and in particular ensure that they enjoy, among others access to health services.

NODPSP XX obliges the state to ‘take all practical measures to ensure the provision of basic medical services to the population’. In *Salvatori Abuki v Attorney General* (Constitutional Case No. 2 of 1997), the court observed that the NODPSP can be employed in the interpretation of the Constitution. In any case, it is a well known constitutional principle that the constitution should be interpreted as a whole. The NODPSP must be read together with the provision in the Bill of Rights (Chapter Four).

It should also be noted that the 2005 Constitutional amendment, which introduced article 8A strengthens the legal status of the NODPSP since the article is in the main body of the Constitution and obliges all organs and agencies of the state to be guided by these objectives and directive principles of state policy.

The Constitution obliges the state to ‘provide the facilities and opportunities necessary to enhance the welfare of women to enable them realize their full potential and

advancement’ (article 33(2)). This provision effectively enjoins the government to ensure that women have access to reproductive and maternal health services, including family planning, emergency obstetric care and safe abortion services.

The Constitution also makes it mandatory for the state to protect women and their rights [including maternal health rights], taking into account their unique status and natural maternal functions in society (article 33(3)). It can be argued that this provision effectively recognizes women’s right to health generally and maternal health rights in particular and creates an obligation on the state to protect such rights.

Article 45 caters for other rights not expressly stated, and provides that ‘[t]he rights, duties, declarations and guarantees relating to the fundamental and other human rights and freedoms specifically mentioned in this Chapter (Four) shall not be regarded as excluding others not specifically mentioned’.

Since the right to health is defined in instruments to which Uganda is a party, it can be contended that the right falls under those rights not specifically stated in the Constitution. In any case, Uganda cannot absolve itself from the responsibility to protect the right to health by relying on the deficiency [lack of express provisions] in its internal law. A treaty in force is binding upon the parties and must be performed by them in good faith (article 26 Vienna Convention on the Law of Treaties 1969).

The right to health and the attendant state obligations can also be read into other human rights such as the right to life, which is guaranteed under Article 22 of the Constitution. It

CONSTITUTION:

Article 33: Rights of women

- (3) The State shall protect women and their rights, taking into account their unique status and natural maternal functions in society

can be argued that denying a woman access to life saving health services such as emergency obstetric care or post abortion care is a violation of her right to life.

It should be noted that a state denies the right to life not only through summary, arbitrary and extra-judicial executions but also through failing to ensure that basic needs such as health care are catered for.

For example, in the Indian case of *Paschim Banga Khet Mazdoor Sanity and Others v. State of West Bengal and Anor*(1966) AIRSC 2426), the Supreme Court of India held that denial by various government hospitals of emergency treatment for serious head injuries violates the right to life under the Indian Constitution. Their right to life should not be subjected to the availability of resources, or any other circumstance whatsoever.

CONSTITUTION:

Article 24:

Respect for human dignity and protection from inhuman treatment

No person shall be subjected to any form of torture or cruel, inhuman or degrading treatment or punishment

Further, article 24 of the Constitution, which concerns respect for human dignity and protection from inhuman treatment, provides that '[n]o person shall be subjected to any form of torture or cruel, inhuman or degrading treatment or punishment'. Can't one argue for example that denying a woman access to emergency obstetric care violates her right to be free from torture, cruel, inhuman or degrading treatment? Article 41, which guarantees the right of access to information, can also be used to argue that the state violates this right when it does not disseminate information on access to reproductive and maternal health services.

4

THE POLICY FRAMEWORK: AN OVERVIEW

4.1 NATIONAL DEVELOPMENT PLAN

THE National Development Plan (NDP), which replaced the Poverty Eradication Plan (PEAP), recognizes the vital role played by good health in socio-economic development and the advancement of the well-being of individuals and populations in the country. It aims at accelerating socio-economic transformation to achieve the national vision of a transformed Uganda from a peasant to a modern prosperous economy, which is able to cater for issues of human development such as education and health.

The NDP notes key maternal health indicators such as the high fertility rate, poor access to family planning, and low contraceptive rate and laments that some of the MGDs like reduction of the MMR to 131/100,000 live births are not likely to be achieved.

4.2 THE NATIONAL HEALTH POLICY (NHP)

LIKE the 1999 NHP, the 2009 NHP whose overall objective is to ensure a good standard of health to all Ugandans, aims at promoting access to education, health services, and clean and safe water. The policy recognizes the critical role played by a healthy population in the socio-economic development of the country.

The policy covers a wide range of issues such as the underlying determinants of health in both communicable and non-communicable diseases. It also addresses such other issues as health resources, infrastructure and financing, monitoring and evaluation of relevant health interventions.

NATIONAL HEALTH POLICY:

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.

4.3 THE HEALTH SECTOR STRATEGIC AND INVESTMENT PLAN

UNLIKE the HSSPI and II, which couched health issues in general terms, the Health Sector Strategic and Investment Plan (HSSIP) adopts a rights based approach and specifically states that health is a fundamental human right that is enshrined in the Constitution and several legal instruments that Uganda has ratified.

The HSSIP calls upon the government to make health services available, accessible, acceptable and of good quality especially for vulnerable and marginalized groups. It provides for a Minimum Health Care Package, which includes maternal and child health; prevention and control of both communicable and non-communicable diseases; and health promotion, disease prevention and community development. Like the NDP, it cautions that unless the government devises strategic and deliberate investments in the health sector, it is likely not to realize the MDGs in the area of health.

4.4 THE NATIONAL ADOLESCENT HEALTH POLICY (NAHP) AND REPRODUCTIVE HEALTH POLICY (RHP)

THE 2004 NAHP is aimed at integrating young people in the development process. The policy recognizes the critical role played by adolescents in the development of the country and stresses the need for their participation in the development, implementation, monitoring and evaluation of programmes and interventions intended for their benefit.

The policy also emphasizes the need to for an enabling socio-economic environment, which ensures equitable, high quality and accessible adolescent health services.

The policy has a number of targets including:

- 1) doubling the contraceptive use rate among sexually active adolescents;
- 2) raising the age of first sexual intercourse to 18 years;
- 3) promoting abstinence from sex before marriage and/or safe sex;
- 4) ensuring availability of appropriate primary health care facilities, including post-abortion family planning counseling and services;

-
- 5) reviewing the abortion legislation in order to improve the available abortion related services; and
 - 6) ensuring that school girls who become pregnant continue with education after they have delivered. Like the NAHP, the RHP contains a number of critical health services such as family planning, emergency contraception, maternal health care, pre- and post-natal care.

3.5 THE NATIONAL GUIDELINES AND SERVICE STANDARDS FOR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (THE GUIDELINES) 2006

THE Guidelines aim at developing a comprehensive sexual and reproductive health framework to guide policy makers and health workers in the training and provision of sexual and reproductive health services. One of the cardinal objectives of the Guidelines is to promote the accessibility and affordability of sexual and reproductive health services.

The Guidelines cover critical maternal health issues such as family planning, safe motherhood, including safe delivery and post-natal care, abortion and post-abortion care.

According to the Guidelines, services for termination of pregnancy can be granted in the following circumstances: in case of severe maternal illnesses threatening the health of a pregnant woman for example severe cardiac disease, renal disease, severe pre-eclampsia and eclampsia; severe foetal abnormalities which are not compatible with extra-uterine life for example pregnancy, anencephaly; cancer cervix; HIV-positive women requesting for termination; and rape, incest and defilement.

5

LITIGATING THE RIGHT TO HEALTH: WHAT CAN UGANDA LEARN FROM SOUTH AFRICA, KENYA AND INDIA?

5.1 UGANDA: A LOST OPPORTUNITY TO DEFINE THE RIGHT TO HEALTH AND ALLEVIATE THE PLIGHT OF MOTHERS

A PART from medical malpractice cases and those challenging violations of the right to a clean and healthy environment guaranteed under article 39 of the Constitution, there have been very few attempts to challenge the state over violations of the right to health (Twinomugisha, 2007).

In *Joyce Nakacwa v. The Attorney General and 3 Others* (Constitutional Petition No. 2 of 2001), the petitioner alleged that by denying her medical and/or maternity care, the state had violated her human rights under article 33 (3), which obliges the state to ‘protect women and their rights, taking into account their unique status and natural maternal functions in society’.

The state raised a preliminary objection to the effect that the jurisdiction of the Constitutional Court was limited to matters, which fall under article 137 of the Constitution (dealing with constitutional interpretation). It was argued that since the allegations by the petitioner did not require constitutional interpretation, the petition should be dismissed.

The Constitutional Court cited the Supreme Court decision in *Ismail Serugo v. Kampala City Council and Another* (Constitutional Appeal No. 1 of 1998), to the effect that it has jurisdiction to entertain matters that would otherwise fall under article 50 (enforcement of human rights) if this done in the process of a constitutional interpretation under article 137 of the Constitution. The Constitutional Court decided that it had jurisdiction to entertain the petition and dismissed the preliminary objection. Unfortunately, the petitioner passed away before the petition could be heard.

In *Centre for Health and Human Rights and 3 Others v. The Attorney General* (Constitutional Petition No. 16 of 2011), the petitioners petitioned the Constitutional Court seeking declarations to the effect that the non-provision of essential maternal

health commodities in public health facilities and the unethical conduct and behaviour of health workers towards expectant mothers are inconsistent with the Constitution and a violation their right to health and other related rights namely, women’s human rights (article 33 (2) and (3)), the right to life (article 22 (1)), freedom from torture, cruel, inhuman and degrading treatment (articles 24 and 44).

The following were agreed upon as the issues to be determined by the Constitutional Court:

- 1) whether the right to the highest attainable standard of health is a constitutional right by virtue of Article 45 of the Constitution;
- 2) whether the inadequate human resources 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 Health Centres III, IV and hospitals is an infringement of the right to health;
- 3) whether non provision of basic maternal health care services in health facilities contravenes Article 8A, Objective XIV and XX of the Constitution;
- 4) whether the Government’s non-provision of basic maternal health care package in government hospitals resulting into the death of expectant mothers and their children is a violation of the right to life as guaranteed under Article 22 of the Constitution;
- 5) whether the health workers and government failure to attend to expectant mothers subjects them to degrading and inhuman treatment and thereby contravening Article 24 and 44 (a) of the Constitution;
- 6) whether the high rates of maternal mortality in Uganda contravene Article 33 (1), (2) and (3) of the Constitution; and
- 7) whether the families of Sylvia Nalubowa and Jennifer Anguko who died in Mityana District Hospital and Arua Regional Hospital due to non availability of basic maternal commodities are entitled to compensation.

At the commencement of the hearing, the Attorney General raised a preliminary objection based on the ‘political question’ doctrine. She argued that the petition requires the Court to make a judicial decision involving and affecting political questions. That in so doing, the Court would in effect be interfering with the political discretion of

other branches, namely, the Executive and the Legislature. She further contended that in order to determine the issues in the petition, the Court has to call for a review of all the policies of the entire health sector and make findings on them, yet implementation of these policies is the sole preserve of the Executive and the Legislature.

She finally prayed that the Court is prohibited from hearing the petition since the questions raised therein are non justiciable. In reply, it was argued that the preliminary objection was misconceived as the petition is for the determination of whether the acts and omissions are in contravention of the Constitution and not the determination of a political question. The Constitutional Court stated as follows:

Much as it may be true that government has not allocated enough resources to the health sector and in particular the maternal health care services, this court is...reluctant to determine the questions raised in this petition. The Executive has the political and legal responsibility to determine, formulate and implement policies of government, for inter alia, the good governance of Uganda.....This court has no power to determine or enforce its jurisdiction on matters that require analysis of the health sector government policies, make a review of some and let on, their implementation. If this Court determines the issues raised in the petition, it will be substituting its discretion for that of the Executive granted by law.... From the foregoing, the issues raised by the petitioners concern the matter in which the Executive and the Legislature conduct public business/issues, affairs which is their discretion and not of this court. This court is bound to leave certain constitutional questions of a political nature to the Executive and the Legislature to determine (pp. 25-26).

The Court upheld the respondent's preliminary objection and struck out the petition with no order as to costs since 'the petitioners were motivated by their respective concerns for the plight of maternal mothers, and not for personal considerations' (p. 28). The Court advised the petitioners to pursue alternative remedies in the High Court such as compensation and the prerogative remedies of prohibition, certiorari and injunction.

The question is: what is the implication of the Constitutional Court ruling on the realization of the right to health in Uganda? By deciding that it cannot entertain petitions involving political questions, the Court has effectively denied citizens access to justice in respect of certain Executive or Legislative acts or omissions that contravene socio-

economic rights, including the right to health. The Constitution is clear: judicial power shall be exercised in accordance with the values, norms and aspirations of the people (article 126).

Maternal health issues are legitimate concerns of the judiciary, which is charged with the administration of justice, including issues of social justice. Mothers, like other human beings aspire for a dignified life free from premature mortality caused by failure on the part of the state to meet its constitutional and human rights obligations.

Poverty issues such as maternal health care, which are largely in the socio-economic domain certainly form part of the values envisaged under article 126 and are therefore within the competence of the courts. Judges need to know that socio-economic rights such as health care are particularly relevant for vulnerable and disadvantaged individuals and groups in society who may have limited access to basic needs in order to lead a dignified life.

It should be pointed out that there are genuine differences between civil and political rights on the one hand and socio-economic rights on the other. But these differences should not be exaggerated. Both categories of rights involve political decisions. In General Comment No.9, the CESCR observed as follows:

It is sometimes suggested that matters involving the allocation of resources should be left to the political authorities rather than the courts. While the respective competencies of the various branches of government must be respected, it is appropriate to acknowledge that courts are generally already involved in a considerable range of matters which have resource implications. The adoption of a rigid classification of economic, social and cultural rights [such as the right to health] which puts them by way of definition, beyond the reach of the courts would thus be arbitrary and incompatible with the principle that the two sets of human rights are indivisible and interdependent. It would also curtail the capacity of the courts to protect the rights of the most vulnerable and disadvantaged groups in society (para. 10).

It is important to note that in handling either category of rights, the court aims at the attainment of justice for the parties involved. It is vital for the courts to focus on the underlying values and interests of the more vulnerable and disadvantaged, which human

rights seek to serve. The courts should not rely on antiquated doctrines such as the political question doctrine, which seriously undermine the judiciary's constitutionally guaranteed independence.

Judges should exercise their judicial mind with activism and creativity in order to give a voice to thousands of women whose maternal health rights are violated every year. It is no longer tenable to argue that the judiciary is ill-equipped to adjudicate matters of social policy decided by the political branches of the state. The decision by the Constitutional Court was really extreme deference to the political branches.

An opportunity to clarify on the scope and content of the right to health and the attendant state obligations was lost. The petitioners did not ask the Court to 'determine, formulate and implement policies of government' as alleged but to do the following: examine the allegations that women's human rights were violated through actions and omissions of the state and its officials (health workers), which matters fall within the scope of article 137 of the Constitution.

The Court should have assessed the course of action taken by the state, which is the duty bearer, in terms of legal standards such as 'minimum core content', 'reasonableness', 'proportionality', 'adequacy', or 'appropriateness'.

In determining whether the rights in question had been violated or not, the judges would not have involved themselves in policy design and implementation, which are largely the preserve of the political branches of the state. The judges would simply examine the effectiveness of the measures/means chosen by the state to fulfill the rights in question.

Through judicial review, the Court would find out whether the government legislation or regulations or policies comply with legal standards set out in the Constitution and international human rights instruments to which Uganda is a party. The Court has to ask: How 'reasonable', 'adequate' or appropriate are the means chosen by the so-called political branches to meet the minimum core goals or duties outlined in the legal and policy frameworks? Does the existing health policy comply with required legal standard (e.g. to provide emergency obstetric care)?

Judges can and should play a critical role in the enforcement of socio-economic rights. Otherwise, what would be the purpose of providing for such rights in the Constitution

and international human rights instruments if there is no remedy in a case they are violated? Through the system of ‘checks and balances’, the judges have a critical role to play: to monitor the activities of the Executive and the Legislature in terms of their compliance with the obligations imposed on them by the law (the Constitution and international human rights instruments).

Below, we consider some cases from other jurisdictions where courts have not hesitated to review the implementation of policies affecting socio-economic rights such as the right to health.

5.2 SOUTH AFRICA: INTERPRETING THE RIGHT TO HEALTH USING THE ‘RATIONALITY’ AND ‘REASONABLENESS’ STANDARDS

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

In this case, the Constitutional Court handled issues concerning the right of access to health care. Sobramoney was unemployed and had chronic kidney failure. He asked the court to direct the provincial hospital to provide him with ongoing dialysis treatment and to prevent the provincial Minister of Health from refusing him admission to the renal unit of the hospital. He argued that lack of treatment would lead to his death, which would violate his right to life (section 11 of the South African Constitution) and the right to emergency treatment (section 27 (3)).

The Court dismissed the case on grounds that his claim did not fall under ‘emergency medical treatment’ because his situation was not a case of sudden catastrophe, but ongoing treatment to prolong his life. The Court noted that ‘emergency medical treatment’ refers to the treatment that is available in emergency situations, and is necessary to stabilize the patient and to avoid harm. The Court observed that the hospital guidelines for determining who gets the dialysis treatment had been applied in a fair and rational manner and the right to health care services is limited by the availability of resources.

The Court pointed out that, ‘[a] court would be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility is to deal with such matters’ (para. 29). It should be noted that the Court did not dismiss the case outright but proceeded to hear it on its merits by examining the hospital

guidelines on kidney dialysis in order to ensure that the acts by the relevant authorities were taken *rationally and in good faith*. It scrutinized how the hospital authorities justified their distribution of scarce resources beyond emergency cases. Couldn't the Court have decided differently had Soobramoney been an expectant mother who had developed obstetric complications and had been denied emergency obstetric care by the hospital? It can be argued that access to emergency obstetric care falls within the ambit of 'emergency medical treatment' (Twinomugisha, 2007b).

b) *Grootboom v Oostenberg Municipality and Others* (2000 (3) BCLR 277),

Though this case concerned the right to adequate housing, it is relevant for the discourse on other socio-economic rights such as the right to health. A group of adults and children escaped harsh conditions in which they lived and shifted to private land. Following their eviction and destruction of their building materials, they applied to the Cape High Court to order the government to provide them temporary housing until they got alternative accommodation.

The application was based on the right of access to adequate housing (section 26(1) of the Constitution) and the right of children to shelter (section 28(1)). The High Court found that there was only a violation of the children's right to shelter and not the right to adequate housing.

On appeal, the Constitutional Court decided that the Government's housing programme did not comply with the obligation to take reasonable steps (section 26(2)). The Constitutional Court developed a legal standard of 'reasonableness' as a guide to decide whether the government's programme complies with the demands of the Constitution.

The Court stated that the programme must: be comprehensive, coherent and coordinated; be capable of facilitating the realization of the right; be balanced and flexible, and appropriately provide for short-, medium-, and long term needs; clearly allocate responsibilities and tasks to the different spheres of government, and ensure that financial and human resources are available; be reasonably implemented; and provide for the needs of those most desperate by providing relief for people who have no access to land, no roof over their heads, and who are living in intolerable or crisis situations.

c) *Minister of Health and Others v. Treatment Action Campaign and Others* (2002)5 BCLR 277.

This case involved the right of access to health care. TAC took the Government to court to challenge the state's policy on mother to child transmission (MTCT) of HIV. TAC argued that the Government unreasonably prohibited administering the antiretroviral drug, *nevirapine*, at public hospitals and clinics, except for a limited number of pilot sites. TAC further argued that the Government had not produced and implemented a comprehensive national programme for the prevention of MTCT of HIV.

The court decided that children are especially vulnerable and their needs are 'most urgent', because if they do not access to *nevirapine*, they will die. That since the poor depend on the state to save their lives, the Government's policy not to provide these life-saving drugs was unreasonable and unconstitutional. The court found that the Government's programme to progressively provide women living with HIV and their newborn babies with nevirapine and restricting it to only 20 pilot sites was unreasonable and unconstitutional.

The Court directed that the Government must take all reasonable measures to extend the testing and counseling facilities at public hospitals and clinic throughout the public health sector. The Government should facilitate and speed up the use of *nevirapine* for the purpose of reducing MTCT of HIV.

The TAC case illustrates the point that the state has a duty to do as much as possible within the available resources, to ensure the protection of the most vulnerable groups in society such as expectant mothers and children. Where the state does not take reasonable steps to save the lives of the poor and vulnerable through for example the provision of essential health care, the court would declare that it has not carried out its constitutional obligation to provide access to health care.

5.3 KENYA: TESTING THE RIGHT TO HEALTH UNDER THE NEW CONSTITUTION

Patricia Asero Ochieng and 2 Others v. The Attorney General and Another (Petition No. 409 of 2009)

The case concerned the right to the highest attainable standard of health guaranteed under the 2010 Kenyan Constitution. The petitioners petitioned the High Court of Kenya arguing that their fundamental rights to life, human dignity and health as protected under articles 26 (1), 28, and 43 of the 2010 Constitution respectively are threatened by the enactment of the 2008 Anti-Counterfeit Act, especially sections 2, 32 and 34.

They argued that these provisions affect or are likely to affect their access to affordable and essential drugs and medicines including generic drugs. That under this Act, such generic drugs and medication will be deemed counterfeit goods within the meaning of the Act and therefore liable to seizure any time, which may lead to an increase in the cost of drugs, forcing the petitioners, who are Persons Living with HIV/AIDS (PLHA), to rely on more expensive drugs.

In interpreting the constitutional provision on the right to health and the implications of the contested provisions of the Act, the court extensively referred to the relevant legislative and policy frameworks and noted that if a legislative measure ‘would ipso facto threaten the lives and health of the petitioners and others infected with HIV and AIDS’, it would be in violation of their rights in the Constitution.

The Court also referred to case law from other jurisdictions (e.g the *TAC* case above) and international law. The Court cited General Comment No. 14 (on the right to the Highest Attainable Standard of Physical and mental Health), which notes that ‘the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life’.

The court observed that this implies ‘a situation in which people have access to the medication they require to remain healthy. If the state fails to put in place such conditions, then it has violated or is likely to violate the right to health of its citizens’(para 63). Emphasizing the interdependence and indivisibility of human rights, the judge observed as follows:

In my view, the right to health, life and human dignity are inextricably bound. There can be no argument that without health, the right to life is in jeopardy, and where one has illness that is as debilitating as HIV/AIDS is now generally recognized as being, one's inherent dignity as a human being with the sense of self worth and ability to take care of oneself is compromised'(para 56).

The Court concluded that it was incumbent upon the state to 'reconsider the provisions of section 2 of the Anti-Counterfeit Act alongside its constitutional obligation to ensure that its citizens have access to the highest attainable standard of health and make appropriate amendments to ensure that the rights of petitioners and others dependent on generic medicines are not put in jeopardy' (para 88).

It can be seen from this case that the court was not bogged down by the political question doctrine and other arguments against the justiciability of socio-economic rights. It boldly scrutinized a legislative *act* (Anti-Counterfeit Act) in order to determine whether it is consistent with the state's obligation to protect the right to health under the Constitution and international law. The Court was guided by the desire to protect the rights of vulnerable individuals and groups such as PLHA.

5.4 INDIA: A CREATIVE AND ACTIVIST JUDICIARY

The courts in India have used public interest litigation as a tool to creatively read socio-economic rights into the Constitution in order to promote human dignity and social justice. For example in the 1992 case of *CESC v. Subhash Chandra Bose and Others* (AIR 1992 SC 573), although the majority opinion was of the view that for the right to health to be justiciable, there had to be a legislation explicitly providing for the right, the dissenting opinion by Justice Ramaswamy influenced future approaches by the courts in the sphere of socio-economic rights. Justice Ramaswamy had observed as follows:

The term health includes more than an absence of sickness. Medical care and health facilities not only protect against sickness but also ensure stable manpower for economic development. Facilities of health and medical care generate devotion and dedication to give the workers' best, physically as well as mentally, in productivity.... In the light of articles 22 to 25 of the Universal Declaration of Human Rights, International Covenant on Economic, Social and Cultural Rights and in light of socio-economic justice assured in our constitution, [the] right to health is a fundamental human right to workmen.

In later cases such as *State of Punjab v. Mohinder Singh Chawala* (AIR 1997 SC 1225), it was decided that the right health is integral to the right to life and the government had a constitutional obligation to provide health facilities to its citizens. In *Paschim Banga Khet Samity v. State of West Bengal* (1966) AIR SC 2426, para. 16), the Indian Supreme Court found that the State had failed to provide emergency treatment and decided as follows:

*It is no doubt that financial resources are needed for providing these facilities. But at the same time it cannot be ignored that it is the constitutional obligation of the state to provide adequate medical services to the people. Whatever is necessary for this purpose has to be done. In the context of the constitutional obligation to provide free legal aid to a poor accused, this Court has held [in *Khatri (II) V. State of Bihar* (1981 AIR SC 928)] that the state cannot avoid its constitutional obligation in that regard on account of financial constraints....*

The said observations would apply with equal, if not greater, force in the matter of the constitutional obligation of the State to provide medical aid to preserve human life. In the matter of allocation of funds for medical services, the said constitutional obligation of the state has to be kept in view. It is necessary that a time bound plan for providing these services should be chalked out keeping in view the recommendations of the Committee as well as the requirements for ensuring availability of proper medical services in this regard as indicated by us and steps should be taken to implement the same.

It can be seen from the above that judges in India have expanded the scope of health to include physical, mental and social well being in order to meet the goals of socio-economic justice. They have not hesitated to order government ministries and agencies to perform their obligations. For example in *PUCCL v. Union of India and Others* (Del HC, PIL, 1996-2003), the court ordered the government to follow its guidelines in the manufacture of a vaccine and pass legislation imposing severe punishment on those involved in the manufacture of poor quality drugs.

The judge directed that the Minister of Health and Director General of Health Services and other concerned agencies ‘without further loss of time must ensure [within three months] that the drug manufacturers should not be permitted to market their drugs unless the quality of the drug is approved by a high level committee or body consisting of doctors and other experts of impeccable integrity and eminence’.

6

RECOMMENDATIONS

THE appeal against the ruling in Constitutional Petition No, 16 has a high probability of success. However, whether the appeal is allowed or dismissed, there are certain things that can and should be done in order to keep maternal health rights issues on the agenda.

6.1 LOBBY FOR LEGAL REFORM

It cannot be denied that litigation of socio-economic rights in Uganda requires a firm legal basis in order to avoid any objections on grounds of justiciability. CSOs should lobby for legislative reform, which can be used to enhance the protection of health rights. The entry point should be to lobby Parliament for an amendment of the Constitution so that the right to health, including reproductive health services is explicitly recognized in the Bill of Rights (Chapter Four of the Constitution).

The Constitution should expressly and unequivocally recognize the direct application of international law so that all international treaties to which Uganda is a party become part of the laws of Uganda. A legislation giving effect to article 8A should be enacted in order to give the socio-economic rights in the NODPSP greater legal authority.

In order to reduce the rates of maternal mortality and morbidity in the country, there is also need to lobby Parliament for a review of abortion laws in order to give legal force to the abortion provisions in the National Guidelines and Service Standards for Sexual and Reproductive Health and Rights 2006 discussed above. To this end, Parliament should be lobbied to operationalize article 22 (2) of the Constitution, which provides that ‘No person has the right to terminate the life of an unborn child except *as may be authorized by law*’.

It should be noted that the new procedure of enforcing human rights under article 50, which is by way of ordinary plaint may be unnecessarily lengthy and onerous. It is thus necessary for CSOs to lobby Parliament to operationalize the provisions of article 50 (4) of the Constitution, which provides as follows: ‘Parliament shall make laws for the enforcement of the rights and freedoms in this Chapter’.

A health legislation should also be developed to help in the implementation of the right to health. Lessons can be drawn from the South African National Health Act 61 of 2003, which aims at making effective health services available to the population equitably and effectively and calls upon the state and non-state actors to respect, protect and fulfill the rights of the people of South Africa. It establishes a national health system that seeks to provide people with the best possible health services that available resources can afford.

It allows for some people to receive free health care in public health services and gives special protection to people needing emergency medical treatment. CSOs should lobby to ensure that salient issues in the health policy frameworks are included in the health legislation. For example, the government can be committed by law to progressively allocate say 1.5-2% of the national budget to health per year until it reaches the ceiling of 15%. This is important because of the fact that unlike legislation, policies are not legally binding.

6.2 INTENSIFY CLAIMS OF HEALTH RIGHTS

Regardless of the outcome of the appeal, CEHURD in collaboration with other CSOs and public spirited individuals should intensify claims for health rights. This can be through litigation in the High Court especially based on the explicitly recognized rights such as equality and non-discrimination (article 21 of the Constitution); the right to life (article 22); freedom from torture, inhuman and degrading treatment (article 24); privacy (article 27); rights of the family (article 31); right to affirmative action (article 32); women's human rights (article 33); children's rights (article 34 (3) and (4)); rights of persons with disabilities (article 35); right to a clean and healthy environment (article 39) ; and economic rights (article 40 (1) (a) and (4)).

Health authorities and health workers and professionals can also be sued in the High Court for medical negligence. Complaints can also be made to the professional bodies, which license health workers and professionals, about the way they may have handled patients. These bodies include the Medical and Dental Practitioners' Council, which is charged with the general supervision and disciplinary control of dental and medical practitioners; and the Nurses and Midwives' Council, which oversees the training and conduct of nurses and midwives.

However, all of the above measures require sensitization of the population about their health rights and how to claim them. It may also be necessary to mobilize the masses to actively demand for the provision of health services.

6.3 MONITORING THE AAAQ OF HEALTH SERVICES

CEHURD and other CSOs should carefully monitor the AAAQ of health services in the country and compile the necessary reports preferably annually showing what steps the government has taken towards the realization of components of the right to health such as maternal health care. The monitoring may include examination of the records of health facilities, interviews with patients, health workers and other key informants. The reports assist in monitoring the overall performance of the health sector and checking the progressive realization of the right to health.

7

CONCLUSION

THE right to health generally and maternal health rights in particular are recognized in international human rights instruments, which are binding on Uganda. The Constitution also contains provisions with a bearing on these rights. In pursuit of its obligation to protect the right to health, the state has also developed a number of health policy frameworks. Through Constitutional Petition No. 16, CEHURD has tested the capacity of the Constitutional Court to promote the realization of the rights in question. By relying on the political question doctrine to dismiss the petition, the Constitutional Court chose a legalistic approach, which is antithetical to the progressive realization of social justice issues such as the right to health. The Court should learn from other jurisdictions, which have transcended the so-called political question doctrine and rendered the right to health justiciable. All human beings are always learning, unlearning and relearning. Thus, it may be helpful for CEHURD to organize training workshop(s) on: a) socio-economic rights generally and the right to health in particular; b) judicial enforcement of/litigating these rights. The training workshop(s) should target selected judges, practicing lawyers, CSOs and academia. Perhaps through this training, the Constitutional Court judges and other members of the judiciary may be able to appreciate the importance of maternal health rights to life and human dignity.

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