THE ROLE OF THE STATE IN PROVIDING MATERNAL HEALTH CARE, A UGANDAN OVERVIEW

BY

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Declaration

I **TULYATUMANYI BEATRICE,** hereby declare that this is an original piece of work and that any information quoted herein from other sources has been acknowledged as being so. Neither the whole nor any part of this dissertation has been submitted to any higher institution of learning or this University as a thesis or dissertation.

APPROVAL

This research report has been submitted with the approval of Dr. Magnus Chima as the university supervisor.

23-8-2018

Date of Approval

Signed

..... (Supervisor)

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Acknowledgement

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My gratitude goes to my friend Elizabeth Nampola without her guidance nothing of this quality would have been arrived at and to my employer Mr. Kasozi Joseph for providing me the opportunity to realize my dreams.

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Abstract

The aim of this research is to assess the role of the state in providing maternal health care in Uganda. The right to health care is a core aspect of the broader concept of the right to health which entails the enjoyment of the highest attainable standard of physical and mental health. The World Health Organization recognizes this right as important for a person's health and well being. Various international and regional human rights instruments to which Uganda is a party recognize the right to health care. States parties to these instruments have a minimum core obligation to ensure access to health care for vulnerable persons such as mothers who are pregnant, breast feeding or have just given birth. The International Convention on Economic Social and Cultural Rights has made it clear that the right to access to health goods and services especially for vulnerable groups like mothers should be recognized progressively. The main of the research was to examine the role of the state in providing maternal health care. The concept of gender refers to the distinctive qualities of women and men that are culturally, socially and economically determined. For the purpose of this research gender relations shall be taken to refer to the relations between men and women that are socially, economically, politically, culturally constructed. The main interest of the research shall be the extent to which failure to address such relations affect enjoyment of the right to health by mothers.

CHAPTER ONE

INTRODUCTION

1.0 Overview

Maternal health refers to the health of a woman during pregnancy, child birth and the postpartum period[1]. Maternal health care is defined as care for health of a pregnant woman provided by a hospital or health centre[2]. Reproductive health is defined as a state of complete physical, mental and social well-being and not merely the absence of diseases or infirmity, in all matters relating to the reproductive system and to its functions and processes[3]. Reproductive health therefore implies that people are able to have satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice., as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant[4].

Abortion is the termination of a pregnancy by the removal or expulsion from the uterus of a fetus or embryo prior to viability. The national guidelines[5] pertaining to sexual and reproductive health define post-abortion care as health care given to a woman who has had an abortion, this care that is to be provided on a twenty four hour basis is to be an integral part of sexual reproductive health services. The concept of gender refers to the distinctive qualities of women and men that are culturally, socially and economically determined. For the purposes of this research gender relations shall be taken to refer to the relations between men and women that are socially, economically, politically and culturally constructed. Adolescence is defined as a period of physical, psychological and social transition from childhood to adulthood.

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[1] en.wikipedia.org/wiki/maternal health.
[2] www.collinsdictionary
[3] http://www.undp.org/popin. UNITED NATIONS POPULATION NETWORK
[4] (UN Programme of Action adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994, Para 7.2a).
[5] Ministry of health policy document. www.health .go.ug.

Sexuality is the central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, beliefs, attitudes, values, behaviors, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, and religious and factors[6].

Sexual health refers to state of physical, emotional, mental and social well-being related to sexuality: not merely the absence of diseases, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled[7].

1.1 Background of the Study

Uganda is slow in its progress in the fifth goal of improving maternal health in its Millennium Development Goals. With the 2015 target for maternal mortality ratio at 131 per 100,000 births and proportion of births attended by skilled health personnel set at 100%, Uganda has a long battle in reaching its intended goals. Moreover, the methodology used and the sample sizes implemented by the Uganda Demographic Health Survey (UDHS)[8] do not allow for precise estimates of maternal mortality. This suggests that the estimates collected are erroneous and it is conceivable that the actual rates could be much higher than those reported[9].

While motherhood is often a positive and fulfilling experience for too many women in Uganda it is associated with suffering, ill health and even death. A Ugandan mother's health and life expectancy is among the lowest across the globe. In Uganda, one in every 200 births ends the mother's life[10]. According to the report by the United Nations Population Fund on the state of the world's midwifery the 2010 maternal mortality rate per 100 thousand births for Uganda is 430.

[6] World Health Organization, Draft Working Definition, October 2002. www.who.org.
[7] Supra No.6
[8] Hereinafter to be called UDHS
[9] www.ubs.or.
[10] Dugger Celia (29.july 2011) "promising care: maternal deaths focus harsh light on Uganda "New York Times.

This is compared with 352.3 in 2008 and 571 in 1990. An evident issue concerning mother's health care poses a threat in Uganda and despite the various international, regional and domestic human rights instruments there seems to be significant disregard for maternal health care. the country is ranked 186th out 191 nations[11]. The research will focus on the cause of violation of right to health of mothers by the state and non-state actors which lead to poor maternal health.

1.2 Statement of the problem and justification

In Uganda while as some of the economic social and cultural rights are expressly stated in the 1995 Constitution, the right to health care is conspicuously absent except for muted provisions in the national objectives and directive principles of state policy. Although Uganda has ratified a number of human rights treaties that provide for the right to health, very few attempts have been made by the state and non-state actors to map out the parameters of the right to health care within the domestic context. By the year 2001, only 49 percent of the households in Uganda had access to health care facilities which has been limited by poor infrastructure and shortage of drugs and other necessary equipment for example the basic care packages especially in rural areas where the majority of the population live[12]. There are many lives being lost during delivery, maternal morbidity and mortality are at the increase, a Ugandan mother's health and life expectancy is among the lowest across the globe. In Uganda, one in every 200 births ends the mother's life the research will in understanding the cause of this. According to estimates from The United Nations Institution Children's Emergency Fund[13], Uganda's maternal mortality ratio, the annual number of deaths of women from pregnancy –related causes per 100,000 live births stands at 435 after allowing for adjustments[14]. Women die as a result of complications during the following pregnancy and childbirth and the major complications include severe bleeding, infections, unsafe abortion and obstructed labour. The research will enable the critical examination of the duties of the state and no-state actors. The research will fill the gap by delimiting the nature, scope and content of the right to health care of pregnant and breast feeding mothers, the attendant obligations of the various actors and the possible remedies in the event that the right is violated. The research will help me find and give ways through which Uganda can solve the problem of poor maternal health.

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[11] Maternal and child health care.en.wikipedia.org
[12] PROMOTING COMMUNITY HEALTH UGANDA. www.poverty.actionable.org.
[13] Hereinafter to be called UNICEF
[14] Supra at No.14

1.3 Objectives of the Study

1.3.1 Main objective

- The main objective of this research was to both the positive and negative roles played by the state in the provision of maternal health care.

1.3.2 Specific objectives

- To examine what actually constitutes the right to health of women in Uganda under domestic regulation and international instruments
- To examine the positive and negative roles played non-state actors.
- To examine other factors affecting maternal health in Uganda
- To find out how best the right to health of mothers can be protected, promoted and respected.

1.4 Specific Questions

- What are the direct causes of maternal morbidity and mortality
- How have these direct causes failed to be prevented and/or cured
- How has violation of other rights led to violation of mother's rights to health

1.5 Literature Review

Many other writers, scholars and individuals have shown concern about the right to health but none of the available literature considers in detail the nature, scope and content of the right to the highest attainable standards of maternal health. The literature does not also clearly examine and assess the roles of the state and the non-state actors nor does it evaluate the effect of the failure by the relevant parties to act on the right in question.

OlokaOnyango[15] discussed the right to health care within the realm of economic, social and cultural rights. He gives a conceptual review of the right to health as a social economic and cultural rights and explains how this right can be realized. He also discusses globalization and its effects on the realization of the right to health and impact of globalization on the full enjoyment of human rights. Unlike him, I looked at the right to health of mother in relation to civil and

[15]OkolaOnyango and Udagama (2000) the realization of Economic, social and cultural Rights: Globalization and its impact on full enjoyment of human rights.

political rights as well which in line with the Vienna Declaration and Programme of Action 1993 which provides that all human rights are indivisible, interdependent, and interrelated[16].

Byamukama[17] has argued that economic social and cultural rights such as the right to health care are not rights because they are programmatic, costly and are generally not justifiable. He contends that in resource starved countries like Uganda the right to health should not be recognized as a right. I differed from his arguments because through my research I discovered that the right to health is right like any other right and mostly because its interdependent and interrelated to civil and political rights which to him are the only rights.

Kiapi[18] discussed the right to health under Article 16 of the African Charter which provides that every individual shall have the right to enjoy the best attainable state of physical and mental health.The author also examines the legal interpretation of the right to health provision in the African charter. She looks at the international standards pertaining to the right to health care; the standards set by the African Charter in light of international standards; and discusses the application and interpretation of the right in domestic jurisdictions in Africa, particularly South Africa and Uganda. She concludes that the monitoring and promotion of the right to health by states must go further than domestication of international standards. The courts should be able to monitor the so-called political matters of resource allocation. Unlike Sandra who discusses the right to health generally and it's interpreatation and application in Africa my research focused on the right to maternal health in Uganda, this was aimed at enabling me to fully and effectively examine the Uganda situation.

Muganda[19] analyzed the right to medical care as a major component of the right to health and discusses the indicators of the right to medical care and how it has been violated. He explains the challenges it poses. He analyzed the right to medical care under a social legal perspective and deals superficially contagious diseases in Uganda. His major focus was the general right to health and he does not sufficiently examine the right to maternal health.

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[16] www.unhchr/huridocda.viena declaration and programme of action. Para 5.

[17] Byamukama "what is the right to health, Your Right". A Uganda Human Magazine 3 No. 8 of 2000.www.Hivalert. 18th –april-2013

[18] KiapiSandra(2005) "interpreting the right to Health Under the African Chatter East African Journal of Peace and Human Rights" volume 11 issue 1.

[19] Muganda (2000) "The Right to Medical Care in Uganda: A social, Legal Analysis."

Twinomugisha[20] focused on the protection of the right to health care of women living with HIV/AIDS in Uganda, he examines the factors that affect the protection of the right to health care of women living with HIV/AIDS. He recognized the critical role Anti-retroviral Therapy plays in the rights to life and to health of WRA. Through human rights and gender perspectives the study explores the major constraints to the protection of the right of WRA to acess ART. He analysed the extent to which the legal and policy framework protects this right in Uganda and delimits the scope, contours and content of the right with a particular analysis of the situation of Mbarara Hospital in South Western Uganda. He also identified the obligations of the state and other actors including private persons and the institutions of globalization. He does not discuss the right to maternal health care of all mothers in detail .he only discusses the right to maternal health care of mothers leaving with HIV/AIDS.

Samuel Olara[21]analyzed the cause of the deteriorating situation of women's health. He discussed how the Ugandan Peoples' Defence Forces and the Lord's Resistance Army have contributed to poor maternal health in Northern Uganda through rape and subsequent infection of HIV/AIDS. However he only discussed the health situation of mothers living in internally displaced persons' camps.

Bright C Toebes[22] analyses the right to medical care as one of the social economic and cultural rights. She discusses the current implementation of the right and the international procedures that have been taken. However, her writings have been widely criticized due to the fact they are mainly applicable in developed countries like England and Netherlands as compared to Uganda.

In Nepal's Human Rights year book[23] she discussed the right to medical care and according to her medical care is still a cry for the moon for majority of the people. However, her book fell

[20]Twinomugisha (2007)protection of the Right to Health Care of women living with HIV AID in Uganda. HURIPEC working paper no.5

[21] United Nations high commissioner for refugee(UNHCR)Rape; the hidden weapon against women in war-torn Northern Uganda, The monitor publications www.unhrc.orgpg 1.

[22] S.J Jejeebhoy. Empower Women, ensure choices, key to enhancing reproductive health. Published by Bio Info Bank institute 2006, http;//. Bio Info.pi/autho;jejeebhoypg 15

[23]Human Rights year book; human rights and social justice informal sector services center 1999 pg 77

short of looking into the character of the right to medical care, it did not mention the factors that lead to the violation of the right to medical care.

Doval[24] argued that there is now general acknowledgment that violation of human rights including systematic gender discrimination worsens the health situation of women whereas equality between men and women improves women's health situation as discrimination creates an environment conducive for the violation of women's right to health, However he lays more emphasis on the gender factors that worsen women's health situations ignoring the biological factors for example their role in reproduction.

Rebecca J Cook, Bernard M Dickens and Mahmoud Fathalla[25] discuss the right to maternity protection under the International Covenant on Economic Social and Cultural rights and the international covenant on the Elimination of all forms of discrimination against women, they also discuss the right to maternity protection during employment arguing that the maternal health of women during employment has been an objective of the International Labor Organization since its establishment in 1919. They also point out that much remains to be done to ensure that the legal protection available in principle becomes effective in principle. They do not however discuss the right to maternal health care comprehensively they only look at it as a component of women's reproductive health rights hence leaving a big gap which is filled by my research because I discuss the right to maternal health comprehensively and in detail and examine this right as a right on its own and not only as component of women's reproductive health rights.

Twinomugisha Ben K[26]. In his paper entitled "Barriers to the Protection of Rural Women's Right to Maternal Health Care in Uganda? He argues that neither the 1995 Constitution nor any other legal instrument expressly provides for the right to health in general, and rural women's rights to maternal health care in particular, although a careful scrutiny of some constitutional provision shows that it is possible to locate this right in the domestic context with the attendant state obligations to protect the same. He states that the barriers to protection of women's right to maternal care include globalization, inadequate funding for the health sector, lack of a human

[24]Doval L(1995) WHAT MAKES WOMEN SICK; Gender and the political economy of health Lancet 350 pg 750
[25]In their textbook entitled "reproductive health and human rights". A copy is available at www.law.utoronto.cal/rehealth/PUB- HUMAN RIGHTS Dynamics pdf.
[26] East African Journal of Peace and Human Rights.2005 Volume 11ISSUE 1

rights approach to poverty reduction strategies, privatization, inequitable gender relations related to women's limited access to physical and financial resources and religious and cultural traditions. His discussion is not comprehensive as he only looks at the barriers to the protection of rural women's rights to maternal health care in Uganda ignoring vulnerable women in the urban and semi urban areas. My research provides a comprehensive analysis of the right to maternal health of all women in Uganda taking in to account the fact that not all women in urban and semi urban areas have adequate access to economic resources to enable them access maternal healthcare service because according to the concept of intersectionality which comes out of metaphor coined by the critical legal theorist Kimberle Williams Crenshaw[27] women experience oppression in varying configurations and in varying degrees of intensity from many different and various biological and other axes of identity which interact on multiple and often simultaneous levels, contributing to inability of women to fully enjoy their right to maternal health care services, therefore living in rural areas in rural areas is only one of these factors.

My research fills this gap by looking at maternal health rights of all women in Uganda without limiting the scope to only women in rural areas while laying more emphasis on the roles of the various actors.

1.6 Methodology

The research methodology used was the scientific approach which followed sequential steps of problem identification, hypothesis, development, deductive reasoning, collection and analysis of date.

Data collection was by use of questionnaires, review of available data and interviews. The other methods of data collection processing used included the use of sampling, dialogical methods, library materials and personal observations which were also employed.

- Manual collection of information and data
- Computer aided development of data and report. The internet was of importance especially where library information was not available or inaccessible.
- Non experimental designs of qualitative from that is to say analytical designs which involved both historical analysis and concepts of development were employed.
- Target groups were pregnant and breast feeding mothers and women who had ever given birth generally, professionals were also consulted.

[27] https://en.wikipedia.org/wiki/intersectionality. 18th –april-2013

Process

A three stage process was followed in the study namely literature review field consultation, internal interviews, analysis and synthesis.

Stage one involved a comprehensive review of both published and grey literature on human rights and health in Uganda. On the basis of this review key issues relating to the right to health and women in Uganda were identified these were then be used in the construction of a semi structured interview guide that was used in the actual field work

Stage two was the actual field work; this was conducted in four randomly selected districts representing the country's geographical regions of East (Iganga district) West (Mbarara district) Central (Kampala District) and Gulu District for Northern Uganda

Stage three was a detailed analysis of the findings from the study through a series of internal discussions and synthesis. Each round of visit to a given site was preceded by a pre visit to make appointments, agree on meeting places and to sound out potential respondents.

Sampling Frame and Unit of Investigation

The specific units of investigation were hospitals and villages. I selected two villages and one main hospital from each district this was aimed at maximizing diversity. In using the sampling frame I aimed at deriving as much qualitative information as possible to complement or compare with the date obtained from other surveys

Methods Used

Qualitative research methods were used using a semi-structured dialogue guide. I spentatleast five days in each location (village or hospital) interacting with medical personnel and conducting interviews with pregnant and breast feeding mothers

1.7 Chapter Layout

- Chapter one has; the introduction, working definitions, background of the research, statement of the problem and the justification objectives of the study, research hypothesis, literature review and the research methodology.

- Chapter two contains; Thelegal framework under which I examined the right to health of mothers in the domestic perspective, the right to health of mothers under the regional legal instruments and the international legal framework. This chapter also includes a critical analysis of the policy and institutional framework.
- Chapter three includes; the state obligation and obligation of the non-state actors under the international regional and domestic legal instruments.

- Chapter four contains the key findings from the research
- Chapter five contains recommendations and conclusions resulting from the research and challenges of the research.

CHAPTER TWO

THE LEGAL FRAMEWORK

2.1 Domestic Instruments

The Constitution does not expressly provide for the right to healthcare because of this some may argue that the right to health is not justiciable in Uganda. Iain Byrne has correctly observed that non-codification of the right to health in domestic law is not necessarily a bar to its adjudication and enforcement by the courts[28]. He points out that the lack of constitutional protection for health rights provides courts, lawyers and activists with significant but not insurmountable challenges for enforcement. It should be noted that the constitution contains various provisions which an activist court can apply to protect the right to health generally and the right to maternal health care in particular.

Article 17(1)(j) of the 1995 constitution provides that every citizen of Uganda shall create and protect a clean and healthy environment. If mothers are to receive high quality maternal care the environment in which they live and give birth from must be clean, hospitals must ensure good hygiene through cleaning places where mothers are admitted and providing clean water for midwives and mothers to clean themselves after delivering a baby.

Article 33 of the constitution provides that women shall be accorded full and equal dignity of the person with men this provision is to ensure that women enjoy the right to health which includes maternal health care on the equal footing with men. Article 33(2) thereof provides that the state shall provide the facilities and opportunities necessary to enhance the welfare of women to enable them to realize their full potential and advancement such facilities and opportunities in order to enhance the welfare of women must ensure their enjoyment of the right to maternal health care. Article 33(3) thereof provides that the state shall protect women and their rights taking into account their unique status and natural maternal functions in society. This is the article that expressly and directly protects the right to maternal health care unlike most of the other constitutional provisions that provide for formal equality between men and women in the

[28] Byrne [2005] "making the right to health a reality: legal strategies for Effective Implementation" A paper delivered at the commonwealth Conference, London, September at pg. 1.

enjoyment of human rights which include the right to health this article provides for substantive quality as it goes ahead to recognize the fact that women as mothers with maternal functions need extra attention if they are to enjoy their rights and freedoms on the equal footing with men. Article 20(2) of the constitution provides that all organs, agencies of government and persons shall respect uphold and promote all rights and freedoms of the individual and groups enshrined in chapter four of the constitution. This provision ensures that women's right to maternal care is respected by everyone including organs and agencies of government it ensures that everyone can be held accountable for violating the right to health generally and the right to maternal health care in particular. The article implies that even artificial person like private clinic or hospitals can be held accountable for the violation of the right to health in general and the right to maternal health care in particular.

Article 23(d) provides that no person shall be deprived of personal liberty except for the purpose of preventing the spreads of an infectious or contagious disease this is in line with the Public Health Act which provides for quarantine measures, compulsory notification and treatment[29] which all aim at protection and promotion of the health of the public at large and the health of pregnant mothers in particular by allowing for the removal of persons with communicable diseases from the public pregnant mothers are protected from acquiring such diseases and their health is thereby protected and promoted.

Objective XX of the national objectives and directive principles of state policy provides that the state shall take all practical measures to ensure the provision of basic medical services to the population. This implies that the state has an obligation to provide maternal health care through provision of basic medical services to mothers since they are part of the general population.

ObjectiveXXI provides that the state shall take all practical measures to promote a good water management system at all levels. If the state is to succeed in promoting the provision of maternal health care then it has to ensure that pregnant and breast feeding mothers have access to clean water, water is life and good hygiene cannot be achieved in the absence of water. Maternity wards in hospitals need to be mopped if mothers are to be protected from getting diseases that arise as a result of staying in a dirty environment for example diahorea and typhoid.

[29] Part III and IV of the Public Health Act

Objective XXII provides that the state shall take appropriate stepsto encourage people to grow and store adequate food, establish national food reserves and encourage and promote proper nutrition through mass education and other appropriate means in order to build a health state. It should be noted that the right to food is an integral part of the right to health in general and the right to maternal health care in particular, acute hunger can lead to death of pregnant mothers and poor nutrition can lead to pregnantmothers developing complications hence if the state is to prevent or reduce the high maternal mortality rates t has to ensure adequate provision of food to pregnant and breast feeding mothers.

Some commentators argue that National Objectives are not binding on the state since they are located outside the substantive sections of the constitution. The Uganda Constitutional Commission charged with collecting views on the constitution and making suggestions for a new constitution stated in its report[30] that the public wanted constitutional protection for economic and social rights but due to financial and economic inability to protect and promote such rights the commission found it prudent not to make them enforceable rights this explains why there is no express provision of the right to health in the substantive section of the constitution but only embedded in objectives. However, the constitution is clear under objective 1[1] that objectives must guide all organs and agencies of the state, including courts, in the application and interpretation of the constitution. Experiences from other jurisdictions show that a creative court can effectively apply objectives or directive principles of state policy. For example in the Indian case of *KeshavanandaBharati v State of Kerala*[31] the supreme court stated that although article 37 of the Indian Constitution expressly provided that the DPSP are not enforceable by any court, they should enjoy the same status as traditional fundamental rights. Furthermore the amended constitution provides under Article 8A that 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. It can be said that the foregoing article which exists as a substantive part of the constitution, renders the objectives and DPSP in the constitution justiciable. The article makes it mandatory for the state to take them into account in the governance of the country which governance includes provision of maternal health care.

[30] Report of the Uganda constitutional commission; Analysis and Recommendations. Available at library.umu.ac.ug
[31] [1973]4 SCC 225

The constitution guarantees the right to life under article 22[1]which right is an integral part of the right to health because protection of the right to life through for example preventing maternal mortality can lead to protection of the right to health generally and the right to maternal health care in particular. The right to life has been interpreted to move beyond the arbitrary taking of life or through the death penalty in the *PaschimBangaKhetmazdoor sanity and others v state of west Bengal*[32] the supreme court of India held that denial by various government hospitals of emergency treatment for serious head injuries violated the right to life. The court held that the right to emergency medical treatment formed a core component of the right to health, which is an intergral part of the right to life. Maternal health cannot be protected if the mothers' right to life is being violated. In *Malawi Savings Bank v Bonny Brighton Kolombola*[33] the court noted that life must not be limited to breathe alone but extend to all other activities that give breathing humans dignity. For mothers in Uganda to live a good quality life and to ensure that their right to life is guaranteed they require maternal health care.

The constitution provides for other rights not specifically mentioned and enacted. Article 45 states that the rights, duties, declarations and guarantees relating to the fundamental and other human rights and freedoms specifically mentioned in this chapter shall not be regarded as excluding others not specifically mentioned. Since the right to health is defined in international and regional instruments to which Uganda is a party it can thus be argued that the right to maternal health care is covered under those rights not specifically included in the constitution.
The National Drug policy and Authority Act establishes the National Drug Authority whose obligations include ensuring the availability at all times of essential efficacious and cost effective drugs to the entire population of Uganda as a means of providing satisfactory health care and safeguarding the appropriate use of drugs. This implies that in the provision of maternal health care the national drug authority must ensure that essential efficacious and cost effective drugs are available to mothers.

The National Medical Stores Act establishes the national medical store which is charged with the efficient and economic procurement, storage, administration, distribution and supply of medicines and other related goods. This ensures that mothers access such medicines and related goods which are required for the improvement and maintenance of their good health.

[32] [1966]AIRSC 246
[33] Civil Cause No. 1394 of 1997

The Venereal Diseases Act provides for the examination and treatment of persons infected with venereal diseases and for other matters connected therewith or incidental thereto. The act under section 2 provides that any medical officer of health may require any person who he or she knows or reasonably suspects to be infected with a venerable disease to submit himself or herself for examination at such time and place as the medical officer of health may direct thereby ensuring that mothers with venereal diseases are examined and get the necessary treatment.

The Patients' Charter[34] protects patients' rights in the course of seeking health services and under article 5 it provides that a patient shall be entitled to appropriate health care with regard to both its professionalism and quality assurance based on clinical need, this implies that mothers are entitled to appropriate maternal health care with regard to both its professionalism and quality assurance based on clinical need.

2.2 Regional and International Instruments

The preamble to the WHO constitution provides that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

The universal declaration of human rights under article 25 provides that everyone has a right to a standard of living adequate for the health and wellbeing of himself and his family, including food, clothing, housing and medical care and necessary social services and the right to security in the event of sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. Article 25(2) thereof explains that motherhood is entitled to special care and assistance, this recognizes women's right to protection, care and aid during pregnancy and the nursing period.

The International Covenant on Economic Social and Cultural Rights provides the most comprehensive provisions on the right to health in international human rights law. Article 10(2) thereof requires that special protection should be given or accorded to mothers during a reasonable period before and after child birth. This provision ensures that the state provides adequate maternal health care services to protect mothers from complication caused by pregnancy and child birth while putting into consideration their special contribution to society. In accordance with article 12(1) of the Covenant, State parties recognize the right of everyone to the

[34] Available at library.umu.ac.ug

enjoyment of the highest attainable standard of physical and mental health, while article 12(2) enumerates by way of illustration a number of steps to be taken by the states parties to achieve the full realization of this right accordingly, the right to health is recognized, inter alia in article 5(e) (iv) of the International Convention on the Elimination of all forms of Racial Discrimination of 1965.

Article 12 of the International Convention on the Elimination of all forms of Racial Discrimination against women obliges states parties to take all appropriate measures to ensure that women are guaranteed access to health care. The state is enjoined to ensure that women in rural areas enjoy the right to have access to health care facilities. Article 12(2) thereof requires provision of free maternity services where necessary. States are enjoined to ensure that women have 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. Under Article 5(b) of the same convention states parties agree to take all appropriate measures to ensure that family education includes a proper understanding of maternity as a social function.

Article 24(2) of the International Convention on the Rights of the Child calls upon state parties to ensure appropriate prenatal and postnatal care for mothers. This obliges the state to ensure motherhood is safe which is vital to the reduction of maternal mortality and morbidity.
The Maternity Convention, number 3 of 1919[35] stipulates in Article 3(c) that pregnant women are entitled to free attendance by a doctor or qualified midwife. This ensures that working mothers enjoy their right to maternal health care services given the increasing participation of women in the workforce and the rising social expectations regarding women during their child bearing years. This convention was revised in 1952[36]. The 1952 Convention provides in Article 4(1) for the material support of mothers through financial benefits and medical care. Article 4(3) explains that medical care includes prenatal confinement and postnatal care by qualified midwives or medical practitioners as well as hospitalization care where necessary; freedom of choice of doctor and freedom of choice between a public and a private hospital where applicable.

[35] ILO, Convention concerning the employment of women before and after childbirth (Geneva: 1919), ILO Convention C3, 38 UNTS 53, revised in 1952.
[36] ILO,Convention concerning Maternity protection (revised) (Geneva: ILO, 1919), ILO Convention C103, 214 UNTS 321.

Article 16(1) of the African Charter on Human and Peoples' Rights provides that every individual has a right to enjoy the best attainable state of physical and mental health.
The right to health is closely related to and dependent upon the realization of other human rights as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non discrimination, equality, the prohibition against torture, privacy, access to information and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health.

2.3 Policy Framework

There are a number of policies that have been set up to ensure the improvement of maternal health care and these include;
The Quality Improvement Strategic Plan 2010/11-2014/15[37] developed to provide a common strategic framework for quality improvement in Uganda during the five year period the plan is to guide all quality initiatives by all parties at all levels in the health sector. The strategic plan has two sets of objectives meant to achieve broad ranging improvements in the five year period. The first set of objectives and the related interventions are strategic objectives designed to improve the capacity of health systems to provide high quality services. The first set of its objectives and interventions are to prepare the ground for improving the quality of health care. The second set consists of specific objectives to contribute to improvements of the health outcomes in the priority areas.

The National Adolescents' Health Policy for Uganda[38] also exists to ensure that adolescents enjoy their right to health care. This policy is an effort to highlight adolescent health issues and bring them in to the mainstream of health and other social services. The MOH identified reproductive health as a priority programme and that increasing access to quality adolescent health services is one of the strategies to reduce the high maternal mortality in Uganda. The policy aims at contributing positively to the effort to emancipate young girls and ensuring that adolescent health concerns are mainstreamed in all planning activities. It also seeks to strengthen and promote an enabling social legal environment for the provision of high quality accessible

[37] Available at www.health.go.ug.docs/HSSP
[38] www.drt.ug.org.

adolescent health services. Priority under this policy is given to among others pregnant mothers who are still adolescents.

The National Safe Motherhood programme[39] this programme is aimed at reducing maternal morality through the provision of basic health education and increased access to health care, increasing the number of attended births so as to control the occurrence of obstetric fistula, maternal and neonatal respiratory distress and bringing maternal and neonatal care up to World Health Organization Mother-Baby Package standards.

The national policy of promoting maternal health through promoting informed choice, service accessibility and improved quality of health care services[40]. This policy aims at improving maternal health through sensitizing mothers about their health rights and giving them basic health education to enable them to make informed choices. Through this policy the MOH aims at ensuring the mothers especially those in rural areas have access to quality health care services.

The national health policy on reducing poverty through promoting people's health[41]. This policy was adopted in 2009 and it vision is a healthy and productive population that contributes to economic and national development. The goal of this policy is to attain a good standard of health for all people in Uganda in order to promote healthy and productive life. The policy has a number of strategies that government shall ensure that the minimum care package shall not only be used at all levels for service provision but also as an overall planning, budgeting and resource allocation tools. Government shall ensure the prevention of malaria through indoor residual spraying and early diagnosis and treatment, the policy also states that the government shall promote responsible sexual and reproductive health behaviors especially among adolescents and ensure the promotion of household food security and healthier eating habits to improve the nutritional status of pregnant and lactating mothers.

The Uganda gender policy[42] intends to empower women in decision making process as a key to development. The policy guidelines and training curricular issued between 2001 and 2007, the

[39] Available at www.who.int.
[40] Available at www.health.go.ug.docs/Hssp.
[41] www.health.go.ug health. pdf
[42] www.mgisd.go.ug

national guidelines pertaining to sexual and reproductive health and the national standardized curriculum for survivors of sexual and gender based violence which all aim at promoting and protecting women's reproductive rights and to enable them accessing quality maternal health care.

2.4 Institutional Framework

Article 51 of the constitution establishes the Uganda human rights commission whose functions under article 52 are to ensure the protection and promotion of human rights. Its function therefore involves the protection of the right to health in general and the right to maternal health care in particular.

Article 50 of the constitution provides that the enforcement of rights and freedoms is to be done by the courts. Such rights as discussed above include the right to health in general and right to maternal health care in particular.

The ministry of health Uganda[43] is the government body set up with the mandate of policy formulation and policy dialogue with Health Development Partners, resource mobilization and budgeting, strategic planning, regulation advising other ministries of health matters, setting standards and quality assurance, capacity development and technical support, provision of nationally coordinated services such as epidemic control, coordination of health research and monitoring and evaluation of overall sector performance.

Some functions have been delegated to national autonomous institutions including some specialized clinical support functions (Uganda Blood Transfusion Services (UBTS), National Medical Stores and National Public Health Laboratories), regulatory functions (handled by professional councils, National Drug Authority and other regulatory bodies) and research activities conducted by several research institutions and coordinated by autonomous Uganda National Research Organization[44].

The ministry of health's visions to ensure a healthy and productive population that contributes to socio-economic growth and national development. While its mission is to provide the highest possible level of health services to all people in Uganda through delivery of promotive,

[43] www.health.go.ug

[44] Hereinafter to be referred to as UNHRO

preventive, curative, palliative and rehabilitative health services at all levels. Under the ministry of health there is the Community Health Department aim at supporting integrated public health services for control of both endemic and epidemic disease. This is fulfilled through key departmental tasks and these include: Development of Policy guidelines, Technical supportsupervision and Response and coordination for management of epidemics and emergencies in collaboration with other departments and sectors.

CHAPTER THREE

OBLIGATIONS

3.1 State Obligations

A person's interest or need becomes a right in so far as a duty binds another to respect that interest. The right to maternal health care, like all human rights, imposes three types or levels of obligations on state: The primary obligation not to infringe rights directly(the obligations to respect), the secondary obligation to prevent a right from being infringed upon by private actors (the obligation to protect) and the tertiary obligation to ensure rights (the obligation to fulfill). In turn, the obligation to fulfill contains obligation to facilitate, provide and promote. The obligation to respect requires the state to refrain from interfering directly or indirectly with the enjoyment 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 maternal health care. Finally, the obligation to fulfill requires the state to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.

The committee on economic social and cultural rights in its general comment number fourteen gave a detailed meaning of the obligation of the state to respect, protect fulfill with regard to the right to the highest attainable standard of health in general . The same meaning can be given to these obligations with regard to the right to maternal health care. According to general comment number fourteen

The state is under the obligation to respect the right to health by, inter alia refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a state policy and abstaining from imposing discriminatory practices relating to women's health status and needs. Furthermore, obligations to respect include a state's obligation to refrain from prohibiting or impeding traditional preventive care, healing practices and medicines, from marketing unsafe drugs and from applying coercive medical treatments, unless on an exceptional basis for the treatment of mental illness or the prevention and control of communicable diseases. Such exceptional cases

should be subject to specific and restrictive conditions, respecting best practices and applicable international standards, including the principles for the protection of persons with mental illness and improvement of mental health care[45]. The State should refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health, from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, as well as from preventing people's participation in health related matters. States should also refrain from unlawfully polluting air, water and soil e.g through industrial waste from state-owned facilities, from using or testing nuclear, biological or chemical weapons if such testing results in the release of substances harmful to human health and from limiting access to health services as a punitive measure e.g during armed conflicts in violation of international humanitarian law.

Obligations to protect include, inter alia, the duties of the state to adopt legislation or to take other measures ensuring equal access to health care and health related services provided by third parties; to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services; to control the marketing of medical equipment and medicines by third parties and to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct[46]. The state is also obliged to ensure that harmful social or traditional practices do not interfere with access to pre-and post natal care and family planning; to prevent third parties from coercing women to undergo traditional practices e.g female genital mutilation and to take measures to protect all vulnerable or marginalized groups of society in particular women, children, adolescents and older persons, in the light of gender-based expressions of violence. The state should also ensure that third parties do not limit people's access to health related information and services.

The obligation to fulfill requires the state inter alia, to give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation and to adopt a national health policy with a detailed plan for realizing the right to health. The state must ensure provision of health care, including immunization programmes against the major infectious diseases and ensure equal access for all to the underlying determination of

[45] General comment number 14, Paragraphs 34
[46] General comment No. 14, paragraph 15

health, such as nutritiously safe food and potable drinking water, basic sanitation and adequate housing and living conditions[47]. Public health infrastructures should provide for sexual and reproductive health services, including safe motherhood, particularly in rural areas. The state has to ensure the appropriate training of doctors and other medical personnel, the provision of a sufficient number of hospitals, clinics and other health related facilities and the promotion and support of the establishment of institutions providing counselling and mental health services with due regard to equitable distribution throughout the country.

Further obligation include the provision of a public, private or mixed health insurance system which is affordable for all, the promotion of medical research and health education, as well as information campaigns, in particular with respect to HIV/AIDS, sexual and reproductive health, traditional practices, domestic violence, the abuse of alcohol and the use of cigarettes, drugs and other harmful substances. The state is also required to adopt measures against environmental and occupational health hazards and against any other threat as demonstrated by epidemiological date. For this purpose the state has to formulate and implement national policies aimed at reducing and eliminating pollution of air, water and soil, including pollution by heavy metals such as lead from gasoline. Furthermore, the state is required to formulate, implement and periodically review a coherent national policy to minimize the risk of occupational accidents and diseases, as well as to provide a coherent national policy on occupational safety and health services[48].

The obligation to fulfill (facilitate) requires the state inter alia to take positive measures that enable and assist individuals and communities to enjoy the right to health. The state is also obliged to fulfill (provide) a specific right contained in the covenant when individuals or a group are unable, for reasons beyond their control, to realize the right themselves by the means at their disposal. The obligation to fulfill (promote) the right to health requires the state to undertake actions that create, maintain and restore the health of the population. Such obligations include: (i) fostering recognition of factors favoring positive health results, e.g. research and provision of information; (ii) ensuring that health services are culturally appropriate and that health care staff are trained to recognize and respond to the specific needs of vulnerable or marginalized groups; (iii) ensuring that the state meets its obligations in the dissemination of appropriate information

[47] General comment No. 14 Paragraph 36
[48] Supra no.26

relating to healthy life styles and nutrition, harmful traditional practices and the availability of services; (iv) supporting people in making informed choices about their health

The state under progressive realization has the obligation to move as expeditiously and effectively as possible towards the full realization of the right to maternal health care. There is a strong presumption that retrogressive measures taken in relation to the right to health are not permissible. If any deliberately retrogressive measures are taken, the state party has the burden of proving that they have been introduced after the most careful consideration of all alternatives and that they are duly justified by reference to the totality of the rights provided for in the covenant in the context of the full use of the state party's maximum available resources.

3.2 Obligations of Non-State Actor

All members of the society – individuals, including health professionals, families, local communities, intergovernmental and non – governmental organizations, civil society organizations, as well as the private business sector have responsibilities regarding the realization of the right to maternal health care.

The institutions of globalization; it is a trite principle of internal human rights that the primary responsibility to respect, protect and fulfill human rights lies with the state however the globalization process has weaken the capacity of the state to provide social services such as maternal health care. Twinomugisha[49] has urged that Institutions such as the World Bank, International Monetary Fund[50] and World Trade Organization[51] are increasingly direct impact to the ability of the state to provide maternal health care. For instance the World Bank is the largest source of funding for development programmes and compliance of IMF conditionality is a pre-requisite to other sources of funding. The activities of these institutions make policies less transparent. According to the Committee on Economic Social and Cultural Rights[52] international organizations should co-operate effectively with states in relation to the implementation of the right to health at the national level in respect to their individual mandates. The World Bank and IMF are particularly enjoined to pay greater attention to the protection of the health in their lending policies, credit agreements and structural adjustment programme. These institutions are

[49] PROTECTION OF THE RIGHT TO HEALTH CARE OF WOMEN LIVING WITH HIV/AIDS IN UGANDA. HURIPEC working paper No. 5, April 2007, page 16

[50] Hereinafter to be called IMF

[51] Hereinafter to be called WTO

[52] Paragraph 64 General Comment 14

called upon to adopt a human rights approach in their policies and programmes. It should also be noted that the UN charter defines the purpose and the objectives of UN as including the promotion of higher standards of living and the respect and general observation of human rights. As international organizations, the World Bank, IMF and the WTO like any other multinational organizations are the subjects of international law and are therefore bound by the provisions the UN charter. Such organizations are responsible for not violating customary international human rights law as contained in UN resolutions and declarations[53] these institutions should not therefore hide behind their constitutive documents so as to respect human rights. They have a continuing obligation to ensure that they do not impose policies on the country in disregard of benchmarks established in human rights instruments in adition to organizations like the WTO have an explicit obligation to protect public health which would include the obligation to ensure that their policies do not act as barrier to the realization of the right to health such access to maternal care. It is important to point out that the aforesaid international institutions are created by member states. Consequently, state parties especially those of the North have an obligation to ensure that their actions as members of international organizations take due account of the right to health. State parties who are members of the World Bank and IMF should pay greater attention to the protection of the right to health in influencing lending policies, credit agreements and other measures undertaken by these institutions.

Article 52 of the 1995 Constitution provides for the obligations of the Uganda Human Rights Commission and it provides among others that the UHRC has the obligation to monitor the government's compliance with international treaty and convention obligations on human rights, to investigate violations of human rights and to educate the public and create awareness about human rights and to make recommendations aimed at promoting respecting and protecting human rights which include the right to health in general and the right to maternal health care in particular.

3.3 Obligations of Private Individuals

Most violations of the right to health according to Twinomugisha[54] occur in the private sphere especially within the family and the market place as pointed above the state has an obligation to

[53] OlokaOnyango&Udagama 2000
[54] Supra No.28

regulate activities of third parties in order to ensure that they do not violate the rights of its people. CEDAW under Article 2(e) stipulates that state parties should take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise. This in my opinion imposes an obligation on private individuals not to discriminate against women by denying them access to maternal health care, but in general most treaties do no create direct obligations to private individuals. However, individuals have long been held to be directly criminally responsible for crimes against humanity and for war crimes[55] at the national lever the 1995 Constitution imposes obligations on private individuals to respect human rights it provides that it's the duty of every citizen of Uganda to respect the rights and freedoms of others and to protect vulnerable persons against any form of abuse, harassment or ill treatment[56]. The constitution further provides that the rights and freedoms of individuals and groups enshrined in this Chapter[57]shall be respected upheld and promoted by al organs and agencies of government and by all persons. The word 'persons' according to Twinomugisha[58] includes natural and artificial persons and it can be argued that this constitutional provision moves accountability beyond the traditional focus on the state as sole protector of human rights. Private persons whether in the family, community, government or the market can be held accountable for the violation of human rights such as the right to health care which encompasses the right to maternal health. Consequently, private individuals like husbands who deny women access to maternal health care by threatening or committing domestic violence can be held accountable for the violation of the right to access maternal health care and freedom from torture or cruel inhuman or degrading treatment. NGOs, private health facilitates and their workers can also be held accountable.

[55]Brownlie 1979, Principles of Public International Law, Oxford University Press
[56] Article 17 of the Constitution
[57] Chapter four of the Constitution
[58] Supra No. 28

CHAPTER FOUR

KEY FINDINGS

4.1 Role played by the State

The state through its representatives has played both positive and negative roles in the provision of maternal healthcare.

The main factors responsible for maternal deaths relate to the three delays – delay to seek care, delay to reach facilities and intra-institutional delay to provide timely and appropriate are. Slow progress in addressing maternal health problems in Uganda is due to lack of human resource, medicines and supplies and appropriate buildings and equipment including transport and communication equipment for referral.

The state has failed to increase funding for health sector so as to be able to pay the service providers enough salary and also to motivate them, the funds allocated to the health sector are also not enough to facilitate the supply of enough essential equipment needed in hospitals and health centers and to supply essential drugs. The 2012/13 national budget, unveiled in June suggests that health is given low priority because despite disrepair and calls for the health sector to command 15% of the budget, it was given just 7%[59]. Priority is given to security and defense while mothers are left to die of preventable complications and curable diseases like malaria due to insufficient funding from the government.

The State's negative attitude towards the increased funding for maternal health care services is mainly because the right to maternal health is a component of the right to health which is second generation right which rights are not given priority. The state instead gives its first priority to the civil and political rights which are the first generational rights. The challenge to realize the right to maternal health is worsened by the fact that it is a positive right which depends on the government's financial resources and the political will to allocate them to the provision of maternal health care and the fact that the state is only obliged to fulfill this right to the extent of its available resources hence he state can easily be exonerated from the violation of this right on

[59] http://www.globalpovertyproject.com/blog/view/645.

showing that the available resources are limited. In the South African case of *ThiagrajSoobramoney v Minister of Health - KwaZulu-Natala*[60] justice Chaskalson held that the right to health being a second generation right can only be progressively realized to the maximum of the available resources and that the state's limited resources could not accommodate Soobramoney's need for emergency renal dialysis. This explains why Uganda courts are less willing to direct governmental discretion on allocation of resources to the provision of maternal health case services.

It is not like Uganda does not have sufficient funding and resources to tackle issues of maternal health. Since 2000, Uganda's Health Sector Strategic plan has benefitted from direct donor support, accounting for 40% of Uganda's health sector resources. The United States, for example has donated $400million annually as funding for the health sector[61]. The money meant for the provision of maternal health care is lost through corruption and mismanagement of public funds, insensitive and wasteful spending on "trifles" such as the $700 million spent to acquire Russian-made fighter jets and military hardware in peacetime and the notorious entitlement spending on government ministers and members of parliament[62]. The state's spending on maternal healthcare and healthcare in general is sorely insufficient and is responsible to a large degree, for the myriad problems that have plagued the nation's health sector. The government continues to play lip service to propping up the nation's healthcare funding, and as a result, more lives are lost daily because of poor healthcare.

The state has failed to completely eliminate poverty in Uganda and as such women who are not employed lack the source of income to be able to buy their own gloves and razor blades which are demanded by midwives before one can deliver from hospital. In Uganda due to unequal gender power relations most of the resources are in the hands of the men because they are the ones employed in the formal sector while women are employed in the informal sector where they earn low incomes that are insufficient to pay for high quality maternal health care services that are mainly provided in privately owned hospitals like Kampala International Hospital. A mother that I interviewed in Iganga Hospital said she had no money to pay for an operation which she was advised to undergo after developing both vesico-virginal fistula and recto-vaginal fistula

[60] (CCT32/97)[1997] ZAACC, 1998(1)SA 765
[61] www.cehurd.org/2012/07are-Ugandan-women-being-denied-their-rights-to -maternal-healthcare-services
[62] www.cehurd.org/2012/07are-Ugandan-women-being-denied-their-rights-to -maternal-healthcare-services

from an obstructed labour because the procedure which was to be performed in Kampala international hospital was very expensive and she could not afford it. Given the fact that about 35% of Ugandans live on less than $1.25 a day[63] coupled with the increase in the Out-of-pocket health expenditure full enjoyment of the right to maternal health still remains a distant goal for those living I poverty.

The government has provided free maternal health care services to mothers in government hospitals and health centers, especially pain killers to help cure back pains, abdominal pains and headaches which are common in pregnant women. However, these services are not sufficient to meet the demand, the drugs in government hospitals are very few due to inadequate and untimely provision of essential medicines which is worsened by the push system at health center IIs and IIIs. These health centers do not make their own orders based on demand but rather National Medical stores pushes medicines to them which are not priority many times. I was told by a mother who had so far delivered four children from Gulu Hospital that since her first born she was always asked to buy her own gloves, razorblades and most of the essential medicine that she usually took after birth. She added that some nurses steal them and sell them at high prices in their private clinics. Another respondent from Mbarara Hospital said that in most cases the only available drug is Panadol and the rest for example egometrine which helps the mother to stop bleeding after giving birth and ampicillin have to be bought by the mothers themselves. Even nurses in these hospitals demand for money before they can provide maternal health care services, yet many mothers lack the funds to pay for these services which include antenatal, and post-natal services. It should be remembered that it is the duty of the state to ensure women's right to safe motherhood and emergency obstetric services and these are to be provided free of charge provided the available resources are enough.

One Respondent in Nakalama Village in Iganga testified that the reason she had lost her baby and developed complications thereafter was because she had no money to pay for the services needed she said and I quote "I was rushed to Nakalama Health Center at around 5pm by my brother-in-law after I had failed to deliver with the help of a Traditional Birth Attendant and I was severely bleeding my brother-in-law talked to the nurses but they refused to touch me and demanded that we first pay one hundred thousand shillings, we had no money at that time and my husband was away. My in-law went back home to sell one of my goats. He got a buyer at

[63] www.cehurd.org/2012/07are-Ugandan-women-being-denied-their-rights-to -maternal-healthcare-services

around 9pm in the night and by the time he came back the baby had already gotten tired and I had a still birth." She now suffers from vesico obstetric fistula.

Out of pocket health expenditure, the percentage of private expenditure on health in Uganda has increased because of the state's failure to provide free maternal health care services. This expenditure includes any direct outlay by households, such as gratuities and in-kind payments, to health practitioners and supplies of pharmaceuticals, therapeutic appliances and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of mother. In recent years, Ugandan have had to spend more on healthcare, while government spending has stagnated at around 10% of national budget[64]. The percentage of individual Ugandans spending money out of their own pockets on health services dropped slightly from about 57% to 52% in the years 2000 to 2003, coinciding with the government's decision to abolish patient fees in major hospitals at the turn of the millennium. Although the decision to abolish patient fees resulted into an increasing influx of poor patients seeking free access to healthcare, the out-of-pocket expenditures on health ticked up shortly after reaching an astronomical height of 65% in 2006 and has remained steady at that rate since.[65]

The immediate implications of this are that mothers have got to spend huge sums of cash on stocking their own supplies that hospitals routinely, inevitably run out of, these include latex gloves, scissors, cotton wool, razor blades, antibiotics etc. thus, considering that about 35% of Ugandans live on less than $1.25 a day[66], it becomes incredibly difficult, if not downright impossible for a mother with four kids or more in the countryside to stock up such expensive items in preparation for an impending childbirth.

The Government has expressed serious concern over unsafe abortion. The high level of induced abortions among young women in Uganda has led the Government to establish family life education programmes in primary and secondary schools. However, the government has failed to facilitate medical personnel to educate mothers' especially young mothers about safe and legally acceptable abortion. Most of the girls between the age of 14-18 that I interviewed admitted that they did not know their reproductive rights and asked what they would do if they got pregnant

[64] www.cehurd.org/2012/07are-Ugandan-women-being-denied-their-rights-to -maternal-healthcare-services
[65] www.cehurd.org/2012/07are-Ugandan-women-being-denied-their-rights-to -maternal-healthcare-services
[66] www.cehurd.org/2012/07are-Ugandan-women-being-denied-their-rights-to -maternal-healthcare-services

most of them had no idea how they would deal with the pregnancy. A traditional birth attendant born in Layby Gulu District stated that most of the young girls that got pregnant in that area while still studying resorted to induced abortion and most of them ended up with severe complications which end in death. This explains why induced abortion has been ranked as the second leading cause of maternal mortality in the main referral hospital in Uganda. Unsafe abortion accounts for 26 percent of maternal deaths in Uganda[67].

A doctor that I interviewed in Mbarara hospital also said that women bleed to death or develop sepsis from unsafe abortion performed by quacks in backstreet places after they have been denied the services in hospital. Some of the women , he said, seek out the services of the quacks for fear of being stigmatized. Although there are few studies on the subject, experts[68] estimate that 297,000 illegal abortions are performed annually, with 85,000 women treated for complications. Post abortion care is estimated to cost nearly US$ 14 million annually in Uganda.

The epidemic of unsafe abortion takes a tragic toll on women and their families. It possess a significant, avoidable economic burden on Uganda's already underfinanced health system[69]. Post abortion care costs nearly $130 per patient. Most of the costs of post-abortion care arise from treating incomplete abortions. However, a significant proportion can be attributed to more serious complications, such as sepsis, shock, lacerations and perforations. Another major problem is poor understanding of Uganda's abortion laws by the medical personnel employed by the government, although the legal and policy framework as it exists recognizes that there are situations when women need access to safe abortion, a 2012 Technical Guide to understanding the legal and policy framework on Termination of Pregnancy in Uganda[70] by the US-Based center for Reproductive Rights, found the country's abortion laws to be "inconsistent, unclear and often contradictory" and that the confusing content of these laws and policies is compounded by their limited interpretations by Ugandan Courts and other government authorities, such as the statutory councils established to regulate the healthcare professions, the report found that as a result women, healthcare providers and regulators often lack comprehensive information about

[67]Dugger Celia (29 July 2011) "promising care: maternal deaths focus harsh light on Uganda" New York Times
[68]http://www.guttmacher.org/pubs/journals/3118305.html

[69]http://www.irinnews.org/report/96332/uganda-patients-go-private-as-state-sector-crumbles

[70]http://reproductiverights.org/sites/crr.civicactions.net/files/documents/crr_UgandaBriefingPaper_v5.pdf

the content of law and what it permits. Failure by the state to provide information on abortion related laws and policies are fueling differing understanding of the issue to the detriment of those who should be benefitting from them. The state has also failed to promote safe abortion by sensitizing mothers about the circumstances under which abortion is legally accepted. The state has also failed to ensure that abortion services are readily available where the law allows for example safe methods of abortion in cases where the pregnancy poses a danger to the life and health of a mother or of the fetus are not readily available. As a result, women resort to village clinics or traditional healers, or use crude methods such as clothes hungers, hitting the stomach with stones, ingesting a lot of tea leaves or a drug overdose which can result in excessive bleeding and ultimate death in some areas.

The state has refused to withdraw restrictions that the law places on access to safe abortion services, Uganda law only allows for abortion in situations where the pregnancy poses a danger to either the life or health of the mother or of the fetus yet UN recently released a report declaring that countries that restrict access to abortion are violating women's human rights because sexual and reproductive health are a part of a woman's overall right to health[71]. In Uganda abortion is criminalized if it is not performed under the permitted circumstances in section 224 of the Penal Code to preserve the life and physical health of the pregnant woman. The other problem is that most people have perceived the law to prohibit abortion restrictively, most of the respondents sated that abortion was a sin according to their religions these were mostly from the Catholic Church. All these problems are due to failure by the government to sensitize the public and avail them with information regarding legally acceptable abortion. The other problem has been failure by the state to withdraw the reservations on article 14 of the Maputo protocol which allows for abortion in cases of rape, incest and where the pregnancy poses a danger to the mothers' health and life so that the circumstances under which abortion is legally authorized are extended.

The state has made contraceptive services available at government clinics. The Ministry of Health has also laid out a roadmap for providing universal access to family planning, involving the integration of family planning into other health services and it plans to reduce the unmet need

[71] jezebel.com/5853887/un-recommends-everyone-stop-telling-women-what-to-do-with-their-bodies

for family planning to 10 percent by 2022[72]. However, that is for the future presently the contraceptives available are not sufficient enough to enable all the women control unwanted pregnancies, the rate of contraceptive prevalence in Uganda has more or less stagnated. Women do not necessarily have access to family planning services as they would wish. This is why they continue to have a number of unwanted and unplanned pregnancies. Uganda's unmet need for family planning stands at 34.3 present, according to the 2011 Demographic and Health Survey (DHS)[73] women are considered to have an unmet need if they wish to space their children's births or limit childbearing. Just 30 percent of married women of reproductive age use any form of contraception, according to the 2011 DHS[74], and only 26 percent of married women and 43 percent of sexually active unmarried women use a modern method. 42% of the estimated two million pregnancies in Uganda annually are unintended. Only 18.5% of all the women in Uganda use modern contraception methods[75].

The state has failed to eliminate myths and wrong perceptions about family planning through sensitization yet these myths and perception about family planning impact negatively on the uptake of the services. There are so many negative views held by different people including some health workers on family planning methods. For instance there are myths and perceptions that is causes infertility, abnormal fattening, weakening women's sexual libido and energy to work on their famers. It is also widely perceived that family planning is for only women and very few people are aware about methods for males.

The state has failed to eliminate social cultural factors that hinder women's enjoyment of maternal health care services provided by skilled professionals. Most cultures in Uganda are against using modern maternal health care services and favor the use of traditional services like herbs. As high as 80% of childbirths in Uganda use herbs[76]. A doctor in Iganga Hospital agreed that it is possible that lack of knowledge on plant species used to induce labor and speed up childbirth could be one of the main factors that contribute to high maternal mortality in Uganda. Ugandan culture also sees the birthing process as a woman's affair and therefore oftentimes there is little male involvement. In Uganda, it is socially viewed that a woman who had died in

[72] http://www.irinnews.org/report/96437/uganda-family-planning-pledges-need-on-the -ground-action
[73] http://www.ubos.org/onlinefiles/uploads/ubos/UDHS/UDHS2011.pdf
[74] Supra no 11
[75] Supra no 11
[76] www.ncbi.nim.nih.gov/pubmed/16901666

childbirth is equal to a soldier who has died during a war. Maternal death is considered a natural phenomenon and elders encourage the use of herbs, while undermining safe birthing practices with a skilled birth attendant.

The government has made efforts to fight against rapid population growth rates, in recognition of the negative consequences of rapid population growth on per capita incomes and social services. The Government launched a comprehensive population grogram in 1988 and adopted the National Population Police for Sustainable Development in 1995[77]. The main focus of these policies was to strengthen maternal and child health and family planning services and to expand population and family life education campaigns. One objective was to increase the contraceptive prevalence rate from 5 to per cent by the year 2000. Nevertheless the population growth rate is still high which has led to shortage of resources and heavy constrain on the few available resources. Uganda, a country of nearly 35 million (including 8 million women of reproductive age), has one of the highest rates of population growth in the world. Uganda has the world's third fastest growing population (after Niger and Timor)[78], the total fertility rate is also very high, it was at 7.1 children per woman for the period 1995-2000 and in that period the population growth rate was 2.8 per cent. The United Nations estimates that Uganda's population will almost triple to 94 million by 2050[79]. The quality of maternal services in the referral hospitals and health centers three and four have not kept pace with the increasingly swelling Ugandan population, putting significant strains on essential hospital supplies, facilities and staff. It has been reported that one regional referral hospital typically handles obstetric emergencies for about 3 million people[80]. Failure by the government to adequately control rapid population growth has rendered it unable to provide free and adequate maternal health care services.

The state has not adequately provided information about the right to maternal health care. The research found that a majority of Uganda women lack health literacy and in turn seek care in more traditional or homeopathic ways. Through the research I was also able to find out that women have very little knowledge about danger signs during pregnancy and that many women do not utilize healthcare services because they do not understand reasons for procedures. Health

[77] http://www.hsph.harvard.edu/population/policies/uganda.pop.08.pdf
[78] www.ncbi.nlm.nih.gov,Journal list,CMAJ,V.177(3); Jul 31, 2007
[79] www.cehurd.org/2012/07are-ugandan-women-being-denied-their-rights-to-maternal-healthcare-services
[80] www.cehurd.org/2012/07are-ugandan-women-being-denied-their-rights-to-maternal-healthcare-services

literacy is a large issue among women in Uganda. Through interviewing medical personnel I discovered that majority did not look at maternal health care as a right that is guaranteed to all mothers, adolescent girls and women lacked information about maternal health as their inherent right and how to access it yet mothers have the right to be fully informed about their right to access maternal health care services, mothers also have a right to be informed by properly trained personnel before agreeing to treatment or research about the likely benefits and potential adverse effects of proposed procedures and available alternatives.

The state has failed to promote and provide maternal health care services of mothers with disabilities by ensuring that extra care is given to such mothers taking into consideration the fact that they are inhibited due to their physical or mental disability to enjoy maternal health services as on an equal basis with other mothers who are not disabled. The pregnant and breastfeeding mothers with disabilities that I interviewed said that they have difficulty in accessing health services. I also found out that there is limited understanding, by medical personnel of the broad range of risks to which these mothers are disproportionately susceptible as a result of their mental or physical disabilities, for example I discovered that it is almost impossible for a physically disabled mother to have a normal delivery without requiring a C-section, a midwife in Iganga Hospital said that in most cases physically disabled mothers who try to deliver by "pushing' without a C-section end up dying and that mothers who are mentally disabled usually die during birth because they do not understand or comply with what the midwives tell them.
The state has failed to train medical personnel to handle complications and treat diseases that are not common or to enable them carry our research about such diseases and come up with a cure, examples of such diseases include; clampsy, this disease causes the mother to become unconscious and to react aggressively a nurse I interviewed in Mbarara Hospital testified that this condition is very serious as it may in some cases cause the mother to kill the newborn baby and that despite its seriousness there is no treatment in Uganda that can cure it. Another complication is called endometriosis, this occurs when the tissue that normally lines the uterus (endometrium) abnormally grows outside the uterus. The endometrium may grow on the other organs of the female reproductive system and can also affect the bladder or bowel. Symptoms of endometriosis include severe abdominal pain, nausea, bloating, diarrhea, constipation or fatigue especially during menstruation. Additional symptoms can include abnormal vaginal bleeding, pain during or after sexual intercourse, lower back pain or infertility, the cause of this condition is unknown.

There is also another condition caused by abnormal non-cancerous tumors that grow within the muscle cells of the uterus called uterine fibroids. Approximately 20 percent of women under the age of 50 develop fibroids, as estimated by the U.S. Centers for Disease Control and Prevention (CDC)[81]. Problems caused by uterine fibroids can include heavy or painful menstrual bleeding, frequent urination, lower back pain, pain during sexual intercourse or reproductive problems, such as miscarriage or infertility. The only forms of treatment for uterine fibroids available in Uganda according to the information I got from a gynecologist in Mulago Hospital are pain medication and surgery, the state has failed to facilitate research that can lead to finding other alternative treatments. Experience from around the world suggests that about 15percent of all pregnant women will develop obstetric complications and that not all these complications can be predicted especially if the person handling the delivery is not highly skilled.

The state has failed to provide enough labour beds on which mothers deliver. In Iganga hospital there were only three labour beds and yet there were seven mothers at that time who were already having contractions and were ready to get on the labour beds but since the beds were not enough the four mothers had to lay down mats and deliver on the floor. In Gulu hospital there were very few mattresses and those available were uncovered, there was also lack of blankets. According to a 2010 World Bank Report on the health services indicators in Uganda[82], the number of hospital beds per 1,000 patients has plunged from 1.65 in January 1976 to 0.39 in verandas while in labor, or overly crowded hospital wards which is indicative of the surge in the number of poor people seeking free medical help.

The state has failed to ensure adequate supply of water in labour wards yet it is very important for mothers and midwives to clean themselves after delivery of a baby. In Gulu hospital there is no running water in the maternity unit despite the available water tanks. The two water pumps meant to supply water have been faulty for a long time all the taps in the labour ward were not working on asking I was told that they stopped working three years ago, in Iganga Hospital only one tap was working in the whole labour ward which was not enough for everybody those who were caring for mothers had to fetch water in jerry cans which these mothers then used to bather and to clean their clothes which had been soaked in blood.

[81] www.livescience.com/34804-uterine-firboids.html.
[82] http://globalhealth.mit.edu/Uganda-health

The state has failed to ensure that there is sufficient and full time supply of electricity in health centers and referral hospitals. It has also failed to ensure the availability of alternative sources of power like solar power or standby generators to enable maternal health care services to be provided even where hydroelectricity power is unavailable. Only 1 in 4 health facilities country wide has electricity or backup generators with adequate fuel routinely available during service hours, according to the Ministry of Health Report[83]. I was told by a respondent in Iganga hospital who was a pregnant mother waiting to deliver that when hydroelectricity power goes off at night midwives deliver mothers using candles or their cell phone torches or mothers are asked to buy kerosene/paraffin for the lump. This is dangerous as midwives could make mistakes due to insufficient light which is not enough to enable them see clearly what they are doing. Rampant electricity blackouts continue to jeopardize critical life saving procedures to help expectant mothers in major hospitals. Indiscriminate load shedding that are routinely carried out by Umeme, the major power company in Uganda, to purportedly save money from high energy use, undermine patients' health outcomes in several affected hospitals. I n iganga Hospital, I was told that four days prior to my visit at the hospital a patient had died during a cesarean section as a result of load shedding.

The state has failed to train enough man powe needed to sufficiently provide maternal health care, hospitals and healthcare centers are under-staffed. There is a severe shortage of trained midwives and other health workers countrywide. It has been reported that at regional hospitals, almost half the positions for doctors are vacant, which is a representative of a shortfall of 25,000 staff[84]. Obstetrician-gynecologists and midwives are few compared to the number of patients. In Uganda the ratio of health workers to patients is 14 health workers per 10,000 people, this is substantially lower than the WHO recommended number of 23 per 10,000[85]. Such extremely low patient-doctor ratios ensure that the physicians on duty will have to work several long hours in a day to meet the demand for healthcare services. Under such enormous workload, the consequential midwife's fatigue, for example could drive noticeable tardiness in delivering patient care services, further making the healthcare experience deplorable for everyone. The

[83] http://spokynewsug.com/2012/07/15/are-ugandan-women-being-denied-their-rights-to-maternal-healthcare-services

[84] www.cehurd.org/2012/07are-ugandan-women-being-denied-their-rights-to-maternal-healthcare-services

[85] www.cehurd.org/2012/07are-ugandan-women-being-denied-their-rights-to-maternal-healthcare-services

2012 Human Resources for Health Bi-Annual Report by Ministry of Health[86] shows that the proportion of approved positions filled by health workers at all levels nationally is 58%, with a vacancy rate of 42% and some district hospitals having as low as only 16% filled posts. With a total of 803 Health Centre III Government units in the country, they have a staffing gap of 40% with each facility requiring 19 health workers. In Gulu Hospital more than half the positions for doctors are vacant. The time I arrived in Mbarara Hospital there were only two midwives attending to all patients in the labourward. The one I talked to said she was handling admissions, delivery and antenatal all at the same time. In Mulago Hospital one nurse was handling delivery while at the same time attending to mothers who after delivery had been diagnosed with high blood pressure.

Health Workers are poorly motivated by the state and are facing very poor working conditions. Most of the midwives I interviewed stated that the government does not provide breakfast and lunch to them while at work on top of paying them poorly. This explains the many strikes from medical workers against poor conditions and low salaries. In the 2009/20 financial year, the monthly salary of a newly recruited medical officer stood at about Ush. 650,000 ($265) and the starting salary of a senior doctor at around 354,000($145). The take-home pay for nurses and midwives was reportedly as tittle as Ush.120,000 ($50)[87]. This dismal salary structure, the lowest for any particular professional level in East Africa[88], hardly incentivizes medical personnel in Uganda, and is squarely responsible for an increasing exodus of skilld medical personnel out of the country "in search for greener pastures". Ugandan medical personnel have used words like "inadequate, deplorable, unfair, and poor" to describe how they feel about their remuneration packages. As it is, a significant fraction of medical personnel end up working two or three jobs just to make ends meet, with government employees also working in private clinics/hospitals. An unfortunate consequence of this practice is the alleged disappearance of essential medicines and supplies from public hospitals that are ostensibly sold to private clinics and hospitals. Further, health worker's fatigue resulting from overworking is responsible for several bad practices that include alleged rude behaviors towards patients, unexplained absences and the apparent

[86] http://library.health.go.ug/publications/leadership-and-governance-monitoring-and-evaluation/reports/human-resource-health
[87] www.cehurd.org/2012/07are-ugandan-women-being-denied-their-rights-to-maternal-healthcare-services
[88] www.cehurd.org/2012/07are-ugandan-women-being-denied-their-rights-to-maternal-healthcare-services

insatiable desire to ask for bribes from patients who want a quicker access to healthcare, a practice that is prevalent in several hospitals, particularly in the countryside.

The state has filed to ensure that hospitals and other health centers have adequate and sufficient supply of essential medicines and equipment. A majority of health centers and hospitals reported to have regularly run out of essential medicines. Only a third of facilities delivering babies are equipped with basics like scissors, cord clamps and disinfectant, according to a 2010 Health Ministry report[89]. It has been reported that just 1 in 20 facilities has a vacuum extractor for assisted vaginal delivery, whereas a slightly higher number of 1 in 10 facilities have a dilation and curettage kit which is particularly essential for removing a retained placenta[90]. In Gulu Hospital I was told by a respondent who was an obstetrician at the hospital that the hospital had no sutures in stock to sew up women after cesarean sections and that was the reason why caretakers of mothers who were to undergo a caesarean section had to go out and but sutures to be used after the operation. The hospital's sole obstetrician said that even in childbirth emergencies, families must buy missing supplies themselves at nearby pharmacies. Patients without money must beg or borrow them. The supplies that are always missing and which the patients must but include latex gloves, cotton wool and a razor blade to cut the umbilical cord. The Sexual and Reproductive Health Policy Guidelines for Uganda[91] recommend that women visiting health centers for ANC receive, among other things, supplements of iron and drugs for intestinal parasites and are weighed, their blood pressure measured and urine and blood samples analyzed. However, many women do not get this minimum package because they cannot afford due to poverty or because supplies are simply not available. For instance, only about half of pregnant women (51%) received the recommended two tetanus toxoid (TT) immunizations[92]. This is usually caused by insufficient supplies which in turn lead to stock outs.

Transportation is also another issue in Uganda. The state had provided ambulances to transport mothers in emergency situations but these cars are only functional in the urban areas and people in semi urban areas and rural areas do not benefit much from them. A respondent from Layibi in Gulu District told me that when you call for the services of an ambulance you have to wait for a

[89] www.cehurd.org/2012/07are-ugandan-women-being-denied-their-rights-to-maternal-healthcare-services
[90] www.cehurd.org/2012/07are-ugandan-women-being-denied-their-rights-to-maternal-healthcare-services
[91] www.popcouncil.org
[92] www.who.int/immunization

number of hours before it is delivered and that the driver usually demands that fuel be provided before the ambulance can be used, according to her this process takes a lot of time and in most cases the mother dies together with the baby before reaching the hospital yet most families do not own personal cars and cannot afford taxi fares. More remote and rural areas cannot be reached by car but must be reached using a motorcycle, I was told that sometimes the mother who has failed to deliver from home is made to sit on a motorcycle even when the baby's head had already come out, in such cases the baby never survives and the mother will automatically have a still birth that is if she can still be saved by the time she reaches the hospital. These conditions are not ideal in transporting a woman in labour. Difficulty in transportation and lack of transport fair are some of the reasons why women choose to stay home during labor and as a result many pregnant women have died from preventable problems merely because access to hospitals and healthcare centers is extremely difficult.

The state has set up local health centers three and four which serve people in a 12 km radius this has helped to bring maternal health service delivery nearer to the people which is essential for the management of safe pregnancies. However, there is no community transport in form of ambulances to transport mothers with complications to their health centers. These health centers are usually ill-equipped as essential medicines and equipment are usually out of stock. Health centers three and four are also under staffed and the few midwives that are there are poorly paid with no incentives, this explains why they are always absent or delay to report because they have to first work on their farms to make ends meet.

The state has extended maternal health care servives nearer to the villages through the training of Traditional Birth Attendants. The research showed that in rural areas pregnant women seek the help of traditional birth attendants (TBAs) due to difficulty in accessing formal health services and also high transportation or treatment costs. TBAs are trusted as they embody the cultural and social life of the community. However, the TBAs' lack of knowledge and training and the use of traditional practices have led to risky medical procedures resulting in high maternal mortalities. I was told that they use herbs to induce contraction and these herbs have not specific dosage the TBAs use their estimations there is therefore a high risk of overdosing which may lead to the mother's death, I was also told that they do not have money to buy the necessary equipment, one of the Respondents in Mbarara district testified that the first time she delivered with the help of a

TBA she was not asked to buy gloves but the TBA just washed the ones she had used for the previous delivery and used them on her. Such acts can lead to the spread of HIV/AIDS among mothers which can then lead to poor maternal health.

The judiciary as the third arm of government has failed to hold the executive arm of government accountable for it bleaches or violations and to direct it to allocate resources to the health sector in order to comply with the state's obligations under the right to maternal health care. This can be illustrated b the constitutional court's ruling in Center for Health Human Rights and Development and others v. the Attorney General of Uganda[93]. In this landmark lawsuit it was contended that the Ugandan Government violated the two women's rights to life by failing to provide them with basic maternal healthcare. And sought a declaration from the Constitutional Court to that end. On the facts of that case a number of mothers had died as a result of negligence of medical workers in state owned hospitals and health centers among whom were the following, Nalubowa who died on 10th August 2009, after heath officials at Banda Health Centre II where she used to attend antenatal clinics failed to detect that she had twins because the health centre did not have a scan. When Nalubowa went into labour, she was rushed to Banda Health Centre II But Irene Namuli, the only midwife was absent. She was then rushed to Maanyi Health Centre II where she gave birth to her first twin but failed to respond to the contractions inducing drip for her second birth. The doctors at Maanyi recommended her transfer to Mityana main Hospital. The staff at the hospital however, demanded for shs. 50,000 before they could attend to her, money she and her relatives did not have. Left unattended to, Nalubowa later breathed her last bringing to four the number of women who died in government hospitals on that particular day.Anguko Jennifer meanwhile, died at Arua referral regional hospital on 10th December 2010, after her uterus ruptured following 15 hours of obstructed labour. The petitioners petitioned court alleging that this amounted to violation of a number of human rights by the state including among others the right to maternal health care and the right to life. The constitutional court threw out the case arguing that upholding the petition would have forced judges to wade into a political issue that was outside their jurisdiction and came to the decision that the case was unacceptable based on the separation of powers doctrine. The court ruled that it would be unduly interfering with the role of the legislature if it interfered in its policies that this being a political question it must be answered by politicians.

[93] Constitutional Petition No. 16 of 2011

The constitution of Uganda does not explicitly recognize maternal healthcare as a women's rights issue. Except for muted provisions found in the national objectives and directive principles of state policy there is no other provision in the constitution expressly providing for the right to maternal health or the right to health in general. This has prompted some people to argue that the right to health is not justifiable. It has also contributed to the reluctance of courts to hold the executive accountable for violating the right to maternal health care and the right to health in general.

4.2 Role played by the Non State Actors

Medical practitioners have urged government to relax restrictions on abortion and make reproductive health services available to the youth if abortion is to be managed in the country. The health workers during a national conference on safe abortion January 2012[94] advocated for legalization of abortion stating that most fetal terminations are as a result of unwanted pregnancies and if legalized a lot of lives would be saved. They also asked the government to provide information about family planning and safe abortion arguing that little guidance is offered, especially to young women in schools and as a result the young women always end up in desperate measures to get rid of the pregnancies.

The poor conduct of doctors, nurses and midwives has made it difficult for mothers to enjoy maternal health care. I was told by a respondent in Gulu hospital that ever since she arrived she had never been checked by a doctor and the midwives only checked on her once each day for the five days that she had spent in hospital after having a miscarriage. Many other respondents said they were neglected by midwives and doctors and when they came to attend to them most of the nurses and midwives acted in rude ways towards the mothers, one Respondent in Iganga Hospital confessed that she had been slapped by a midwife who claimed she had failed to push during labor. Another respondent in Mbarara Hospital testified that a midwife had called her a villager from healthcare personnel as being an additional reason to avoid seeking professional care during pregnancy and labor.

[94] http://watchmanafrica.blogspot.com/2012/06/300000-uganda-women-carry-out-unsafe.html