WOMEN REPRODUCTIVE RIGHTS: AN EXAMINATION OF THE EMERGING LEGAL PRACTICES IN UGANDA

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Master of Laws

By:

TWIKIRIZE PARTON

LLM/1074/91/DU

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DECLARATION A

"This Thesis is my original work and has not been presented for a Degree or any other academic award in any University or Institution of learning"

TWIKIRIZE PARTON

Date

DECLARATION B

"I confirm that the work reported in this Thesis was carried out by the candidate under my supervision"

BITTOK TITUS (Ph.D)

_____

Date

APPROVAL SHEET

This thesis is entitled " Women Reproductive Rights: an examination of the emerging legal practices in Uganda "prepared and submitted by TWIKIRIZE PARTON in partial fulfillment of the requirements of the Degree of Master in Public International Law has been examined and approved by the panel on oral examination with a grade of PASSED

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ame and signature of supervisor name and signature of panelist

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ame and signature of panelist name and signature of panelist

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DEDICATION

This work is dedicated to God and to my Aunt Alice Musinguzi, My sisters Ahabwe Claire , Tayebwa Cynthia,Kerora Night, Kemisisa Flora,Mr and Mrs Nahamya . Thank you for your prayers and for always being there for me whenever I needed help.

ACKNOWLEDGEMENT

The researcher acknowledges the Almighty God for the gift of life and the zeal to do my research. The researcher is very grateful and indebted to Dr Bittok Titus for his intellectual guidance, moral support and inputs in all aspects of this study.

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LIST OF ACRONYMS

ACHPR	African Charter on Human and People's Rights
AIDS	Acquired Immune Deficiency Syndrome
CD	Compact Disk
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
CRPWD	Convention on the Rights of Persons With Disabilities
EMOC	Emergency obstetric Care
EOC	Equal Opportunities Commission
FAO	Food and Agricultural Organization
FC	Female Circumcision
HAR	Hope After Rape
HIV	Human Immune Virus
HRAG	Health Rights Action Group
HSSP III	Third Health Sector Strategic Investment Plan
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
IDLO	International Development Law Organisation
MDGs	Millennium Development Goals
NDP	National Development Plan
NGO	Non Governmental Organization
NHP	National Health Policy
NODPSP	National Objectives and Directive Principles of State Policy
PLHA	People Living with HIV/AIDS
PPC	Post-Partum Care
PRDP	Peace, Recovery and Development Plan for Northern Uganda
STI	Sexually transmitted infection

UNICEF	United Nations International Children's Emergency Fund
UDHR	Universal Declaration of Human Rights
UHRC	Uganda Human Rights Commission
UN	United Nations
UNDP	United Nations Development Program
WHO	World Health Organisation
WLA	Women Living with HIV/AIDS
FMG	Female genital mutilation
TBA's	Traditional Birth Attendants
THP	Traditional Health Practitioner
TRIPS	Trade Related Aspects of Intellectual Property Rights
UAC	Uganda AIDS Commission
PMTCT	Prevention of Mother to Child Transmission
PEAP	Poverty Eradication Action Plan
ART	Antiretroviral Therapy

LIST OF CASES

Ug v. Dr, Hassan Nawabul & Anor, 2008

R Vs *Amkeyo*, 1917

Salvatori Abuki and Anor v Attorney General, 2005

Minister of Health and Others Vs *Treatment Action Campaign of 2002*

A. S. v. Hungary, 2004

Maria de Lourdes da Silva vs Brazil, 2011

S.K. Garg vs. State of U.P, 1998

Paschim Banga Khet Mazdoor Samiti vs. State of W.B. 1996

Uganda Women Lawyers Association v. Attorney General, 2003

Law and Advocacy for Women in Uganda v. Attorney General, 2006

LIST OF LEGAL INSTRUMENTS

Constitution of the Republic of Uganda, 1995

The Domestic Violence Act 3 (2010)

The Employment Act, (2006)

The Equal Opportunities Commission Act, (2007)

The International Criminal Court Act, (2010)

The Land Act Amendment (2004)

The Penal Code Act of Uganda, Cap 120

The Prevention of Trafficking in Persons Act, (2010)

The Prohibition of Female Genital Mutilation Act 5, (2010)

The National Adolescent Health Policy 2004

The National Health Policy 2009

The National Development Plan 2010

The National Policy Guidelines 2006

The Universal Declaration of Human Rights (1948) UDHR

The International Convention on the Elimination of all forms of Discrimination Against Women 1979 (CEDAW)

The International Convention on Economic ,Social and Cultural Rights (1966) ICESCR

ABSTRACT

This research was focused on the Women Reproductive Rights: An Examination of The Emerging Legal Practices in Uganda. This was examined through different method of tools in relations to An Examination of The Emerging Legal Practices in Uganda, presented a description and explanation of procedures used in conducting the study, particularly in sampling and data collection. Qualitative method was used to collect from sample population earmarked for the study.

The study discovered that the Uganda's healthcare facilities are in a dire state, and maternal health is one of the most affected services. The incidents leading to Constitutional Petition No. 16 of 2011 are an epitome of a widespread systemic problem. The petition demonstrates that many maternal deaths are preventable if the state takes its human rights obligations seriously. Maternal mortality rates remain very high (505 in 2001 to 430 per 100,000 in 2012), with clandestine abortions being a major cause of this. There are very high number of teenage pregnancies, women's limited access to quality reproductive and sexual health services, especially in rural areas, and that the existing sex education programmes are not sufficient, and may not give enough attention to the prevention of early pregnancy and the control of STIs.

Therefore, research recommended that there is a need to explicitly recognize the right to reproductive health care in the Constitution, which could clear any misgivings about the justiciability of the right. However, recognizing the right in the Constitution is not sufficient. Legal and policy instruments must underpin the Constitution.

CHAPTER ONE
THE PROBLEM AND ITS SCOPE

Introduction/Background of the Study

It was not until 1979 that the broad based comprehensive document that places women's rights at the centre of international legal regime was adopted, as a result women's human rights finally emerged and were given force under international human rights law[1]. However reproductive rights like health were relegated to the fields of population and development and notions of reproductive rights as a human right were non- existent .For example the human right to health was narrowly interpreted to exclude women's needs and experiences and failed to address obstacles faced by women in making decisions pertaining to health and obtaining health related services. As a result violations occur to women every day in the context of their families and communities.

In the 1990's , however during the 2 UN conferences' held in Cairo and Beijing, consensus documents that emerged placed women's reproductive rights squarely within the context of human rights and deemed those rights logically within the right to health. It was agreed that reproductive rights embrace certain human rights' that are already recognized in national law, international human rights documents and other consensus documents. These rights rest on the recognition of a basic right to all couples and individuals to decide freely and responsibly the number of children, spacing and timing of their children , to have the information and means to do so and the right to attain the highest standard of sexual and reproductive health[2].

Governments of the African Union (AU) including Uganda in 2003 adopted a new protocol on the rights of women in Africa which guarantees a comprehensive right to women to

[1] B.E Heniandez —truyol 'Human Rights Through a Gendered Lens: Emergence, Evolution, Revolution' in K.D Askin and l).M . Koenig (eds Women and International Human Rights Law (Vol.1, Ardsley, NY:Transnational Publishers ,1999) at 4.

[2] Programme for Action of the international conference on population and development, Cairo, Egypt, 5-13Sep 1994, UN Doc. A/CONF 171/13/REV.1 at Paar, 7.3.

control their reproductive health.[3] Since the promulgation of the 1995 constitution Uganda, there has been some progress in the advancement of women status through Law and policy strategies. Women are now visible at most decision making levels Uganda has gone ahead to pass laws that secure the equality of men and women[4] under the law and protect women from discriminatory customary practices. Uganda[5] in a recent constitutional court decision citing the deaths correlated with the practice of Genital Female Mutilation and its inconsistence with the Constitution of Uganda and international treaty obligations[6]. Further Uganda recently ratified the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol),[7] which supplements the African Charter and provides broad protections for women's human rights.

Despite Uganda's stated commitment to improving reproductive rights, its laws and policies are characterized by restrictiveness and a lack of clarity. Further Reproductive rights continue to be neglected and, at times, blatantly violated. Women continue to lack access to quality maternal healthcare, to family planning services and information, and to HIV services; lack of access to safe abortion and post-abortion care services; discrimination and sexual violence against women, adolescents and schoolgirls.

Human rights can be broadly divided into relative rights, such as sexual nondiscrimination rights, and inherent rights, such as the right to liberty and security of the person. The application of both inherent and relative rights ensures women's reproductive rights. The following analysis starts with the relative right to be free from all forms of discrimination, and then proceeds to an analysis of inherent rights to life, liberty, and security of the person, the right to marry and found a family, the right to private and family life, rights

[3] Ibid 5-13Sep 1994, UN Doc. A/CONF 171/13/REV.1.
[4] Article 31 of the Constitution.
[5] The Anti Female Genital Mutilation Act 2010; see also BBC World News, Uganda bans female genital mutilation, http://news.bbc.co.uk/2/hi/africa/8406940.stm (accessed Jun.10.2010).
[6] Lydia Mukisa, Female genital mutilation illegal, court rules, THE MONITOR (Jul.30,2010)
[7] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo protocol), 32 (Jul. 11, 2003), available at www.achpro.org/english/women/protocolwomen.pdf.

regarding information, education, and assembly, the right to reproductive health and health care, and the right to the benefits of scientific progress.[8]

Statement of the Problem

Women need appropriate measures to eliminate discrimination against women in rural areas in order to ensure access to adequate health care facilities, including information, counseling, and services in family planning[9] and to ensure to women the rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights[10]. These rights continue to be neglected and, at times, blatantly violated by the Ugandan government. Uganda Human Rights Council to closely examine the following human rights issues with respect to Uganda: 1) women's lack of access to quality maternal healthcare, to family planning services and information, and to HIV services; 2) their lack of access to safe abortion and post-abortion care services; and 3) discrimination and sexual violence against women and adolescents. The cases of violation of women reproductive rights are quite rife. Why this? One observation is that the 1995 Constitution does not directly as a separate genie provide for reproductive rights

Despite explicit protection in various human rights treaties, to which Uganda is party,[11]. The constitution just has a normative content that devotes a whole article on women human rights and contains a number of provisions in which the normative content of reproductive rights can be located[12]. There are separate legal instruments dealing with some aspects of reproductive rights such as the FMG Act[13] and Domestic violence Act

[8] Objective XIV the Uganda Constitution of 1995 Section of the Constitution's National Objectives and Directive Principles of State Policy (NODPSP).

[9] Article 12 of CEDAW.

[10] Article 16(1)(e).

[11] Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), *adopted* Dec. 18, 1979, G.A. Res. 34/189, U.N. GAOR, 34th Sess., Supp. No. 51, U.N. Doc. A/34/46, 1249 U.N.T.S.

[12] 2010.

[13] 2010.

2010. Other aspects such as maternal health finds umbrella only under generic statutory provisions. The researcher examined the adequacy of the existing and emerging laws in addressing women reproductive rights, the level of implementation and tried to fill in the gaps.

Purpose of the Study

The general objective of the study is to examine reproductive rights of women in Uganda *Vis –a- vis* international, regional laws.

Research Objectives

The specific objectives of the study were:

To examine the existing laws relevant to women reproductive rights in Uganda in relation to international standards.

To establish the emerging practices and law on women productive Rights.

To examine the efficacy of the laws on women reproductive rights.

To establish challenges hindering the full realization of Women Reproductive Rights.

Research Questions

The study is guided by the following questions

What is the legal framework of Women Reproductive Rights in relation to international standards?

What are the emerging practices and law on Women Reproductive Rights?

Examine the efficacy of the laws on Women Reproductive Rights?

Examine the challenges to realization of Women Reproductive Rights?

Hypothesis

The legislative frameworks on women reproductive rights in Uganda are not adequate.

Women reproductive rights in Uganda fall short of recommended international standards and practices.

Scope of the study

Contextual scope

The study focused on Women Reproductive Rights: An Examination of The Emerging Legal practices in Uganda. Research examined the law on women reproductive rights in Uganda and how it adequately addresses the violations and its compatibility with the international and regional treaties on women reproductive rights.

This study focused on legal framework and other literature on examining Women Reproductive Rights: An Examination of The Emerging Legal practices in Uganda.

Time scope

The study took three month in carrying this research. It focused on period when Uganda Government recognized human rights of reproductive rights under the 1995 Constitution.

Theoretical scope

Research covered the theories feminism of women movement

Significance of the Study

Research will be of interest to a wide audience including Human Rights and Women Rights Activists as well as legal practitioners and policy makers.

Further, it is expected that it will be useful by reproductive health services in highlight the recent legal reforms and development in the UN and African Human Rights Systems regarding women reproductive rights

Nevertheless, contribute to the ongoing programme of reducing mortality deaths and gender equality by removing any discriminatory laws based on prejudices, religion and culture.

The findings will add to the existing knowledge and provide a better understanding of the better understanding of the regional human rights jurisprudence that supports women reproductive rights.

Operational Definitions of Key Terms

Reproductive Health: a state of complete physical, mental and social well- being and not merely the absence of disease or infirmity.

Family Planning: ability of an individual and couples to anticipate and also attain the desired number of children through spacing and fixing their births.

Maternal Mortality: death among women who are pregnant or who have been pregnant during the last 42 days.

Human Rights: these are the most basic, most fundamental of rights premised on the principle of the inherent dignity of human life.

Abortion: the spontaneous or artificially induced expulsion of an embryo or foetus.

Unsafe Abortion: the termination of pregnancy carried out by someone without skills or training to perform the procedure safely or in a place that does not meet the minimum standards or both.

Female genital mutilation: is defined as all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non –medical reasons.

REVIEW OF RELATED LITERATURE

This part reviewed the studies of various writers and experts in various human rights subject on the subject the researcher investigated, that is the examination of the emerging laws on women reproductive rights. The literature review covers the violations of reproductive rights and the causes of such violations. The literature review was done according to the study variables under the sub- themes which will be synchronized with the research objectives.

Concepts, Ideas, Opinions from Authors/ Experts

Rebecca J.; *et al*,[14] Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health therefore implies that people are able to have a 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 right of men and women to be informed [about] and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.[15]

According to the blacks law dictionary[16] the term reproductive rights means "a person's constitutionally protected rights relating to the control of his or her pro-creative activities

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[14] Cook, Rebecca J.; Mahmoud F. Fathalla (September 1996). "Advancing Reproductive Rights Beyond Cairo and Beijing". *International Family Planning Perspectives* (International Family Planning Perspectives, Vol. 22, No. 3) **22** (3): 115–121.

[15] The "Cairo Programme of Action" was adopted in 1994 at the International Conference on Population and Development (ICPD) in Cairo.

[16] Henry Campbell:Blacks Law Dictionary 6th Edition (USA West Publishing Co.).

specifically the cluster of civil liberties relating to pregnancies , abortion and sterilization especially the personal bodily rights of a woman and her decision whether to become pregnant or bear a child."[17]

The term reproductive rights has not yet been defined by any international convention The international conference on population and development [18] was the first international instrument to define what the notion of reproductive rights entails as being:

> *"a state of complete physical , mental and social well being and not merely the absence of disease of infirmity, in all matters relating to reproductive system and its functions and process. Based on the premise that all individuals have basic rights to decide freely and responsibly about the spacing and the number of their children".*

At regional level the African charter on human and people's rights in Africa expressly articulates that women reproductive rights are human rights[19]. Nonetheless, the content and scope of reproductive rights remains controversial. According to Ruth Dixon[20]

> *Reproductive rights as human rights consist of two components – individual freedoms and social entitlements. Realization of the components depends on responsibilities on part of the stakeholders that include individuals, communities, social institutions and more particularly the government as the custodian of state resources.*[21]

The realization of reproductive rights depends on cooperation of all stake holders. Yet, there remains the important task of ensuring that stakeholders carry out their obligations in the global drive to make the enjoyment of reproductive health rights a reality, rather than the 'paper rights'. It seems to be, especially in the developing countries of Africa like Uganda. For emphasis, international treaties, national legislations and constitutions, consensus decisions at international conferences as well as international organizations have echoed and emphasized the sanctity of reproductive health rights.[22] The obligations of

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[17] *Ibid.*
[18] Chapter ii and viii Cairo programme of Action (Cairo conference) sept.1994.
[19] Article 14 .
[20] Ruth Dixon –mueller et.al *"towards a sexual ethics of rights and responsibilities"* 17Reproductive Health Maker 111 (2009) .
[21] *Ibid.*
[22] *Ibid 20.*

stakeholders, especially governments, to create an enabling social, economic and legal structure for the realization of reproductive health rights have resonated in the various international treaties and other mediums.

The Uganda's prevention strategies, attitudes and perceptions towards the impact of the pandemic on various age groups, and the general socio-economic consequences of HIV/ AIDS.[23] However, there is a dearth of literature on economic, social and cultural rights in general and the right to health care in particular. The few pieces of literature correctly discuss the right to health care within the realm of economic, social and cultural rights.[24] Some commentators argue 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 justiciable.[25] Byamukama shares this view and contends that in a resource starved country like Uganda, the right to health should not be recognized as a right.[26] Wandira also argues that the right to essential treatment is not justiciable and the international instruments containing the right to health though binding on Uganda are not enforceable.[27]

However, there is an emerging consensus that health rights are indeed justiciable and enforceable.[28] In her discussion of the right to health under the ACHPR, Kiapi argues that the right to health, like any other right can be invoked and enforced in courts of law.[29] In a generalized manner, Nakadama examines prisoners' right to health in Uganda and provides some recommendations regarding the treatment of inmates with HIV/AIDS.[30] Muganda

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[23], Obbo 1995; Pool et al 2000;Gysels 2001; Tamale 2004.

[24] See for example, Oloka-Onyango 2004; M. Ssenyonjo 2003.

[25] See for example,Vierdag 1978.

[26] Byamukama, 2000.

[27] Wandira 2005.

[28] See for example, An-Na'im 2004.

[29] Kiapi 2005.

[30] Nakadama 2001.

looks at the right to medical care and deals superficially with HIV/AIDS among other contagious diseases in Uganda.[31]

Muwanguzi adopts a much broader approach and looks at all the human rights affected by HIV/AIDS and provides an overview of judicial activism with regard to the human rights affected.[32] Tuhaise brings out the link between gender and HIV/AIDS and surveys the human rights of WLA but without particular attention to the right to health care.[33]

In a study of selected districts in Uganda, the Health Rights Action Group (HRAG) outlines the main obstacles to the realization of some of the rights of PLWA and finds that most of these rights are seriously violated.[34] Kyomuhendo analyses the situation of children and other vulnerable groups in Uganda with regard to infringement of their rights as a result of HIV/AIDS.[35] None of this literature delimits in considerable detail the nature, scope and content of the right of access to ARV's. The literature also does not clearly spell out the obligations of the state and non-state actors towards protection of the right. By critically appraising the legal and policy framework within which women's right to ARV's is protected in Uganda, it is hoped that the study will contribute to the clarification of the scope and contours of the right and the attendant obligations to protect the same.

The study on Gender Relations, explains gender disparities existing in Uganda and how women have been short-changed and by-passed by the development process.[36] Various commentators decry the limited or low participation of women in decision making processes. There is also an increased recognition that women's utilization and access to health care can only be effective when the underlying gender relations such as the sexual

[31] Muganda 2002.

[32] Muwanguzi 2002.

[33] Tuhaise 1998.

[34] HRAG 2004.

[35] Kyomuhendo 2004.

[36] See for example Kasente 2000; Matembe 2002; Tamale 1999.

division of labour, and the access to and control of resources are addressed. It is also recognized that gender plays an integral role in determining an individual's vulnerability to infection, his or her ability to access care, support or treatment, and the ability to cope when infected or affected with HIV/AIDS.[37] The literature also stresses that for the effectiveness of interventions designed to reduce risk or vulnerability or to alleviate the impact of HIV/AIDS to be enhanced, gender differences and gender-specific concerns must be acknowledged and addressed directly.

Although on balance research was conclusive in the direction of the impact of inequitable gender relations on women, it does not consider how gender affects other sources of power. In developing countries like Uganda, class variables intersect with gender to compound the complexity of power relations.[38] In order to appreciate the actual impact of gender relations on access to health care, it is critical to take into account the fact that the forces of globalization increasingly determine the internal domestic structure of such countries.[39] The literature also views men as villains yet there is evidence to show that blaming men for perpetuating all injustices against women is not a productive way to tackle the unequal balance of power in gender relations.[40] Men and women are certainly important in matters of sexual and reproductive health. There is also a tendency to treat women as a homogeneous category, yet as Kabeer[41] has observed, gender relations may be experienced and expressed in different ways, places and time. Through an empirical probing of the issues and concerns at stake, the researcher examined the impact of gender relations on women's right of access to ARV's bearing in mind other crucial variables such as class.

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[37] See for example, Berkley, et al 1990; Kisekka, 1990; Mayambala 1999; Rwabukali 1997.

[38] On this view see, Odim 1991.

[39] See,Hills 1994.

[40] See Twinomugisha, op.cit., note 49.

[41] Kabeer 1991.

Through an examination of international and regional human rights instruments and the 1995 Constitution, I illustrate the point that women have a right to health care, which includes access to ARV's. Though neglected in the past as being vague, costly, and difficult to enforce,[42] there is some evidence that the right to health is beginning to attract more attention at the international level and in some national jurisdictions. Health is increasingly being considered as a human rights issue. However, in Uganda, there have been few attempts by scholars and researchers to consider the scope of the right to health care and its attendant obligations. Like other economic, social and cultural rights, the right to health care has received scant attention especially when contrasted to the amount of time and energy devoted to civil and political rights. Given that the 1995 Constitution does not expressly provide for the right under inquiry, it is necessary to utilize international and regional human rights standards against which relevant national laws and policies may be measured. Consequently, in this section of the paper, researcher presented a synoptic review of these instruments by way of fortifying the argument of the existence of the right in the domestic context.

Related studies

Specific Women Reproductive Rights Violations in Uganda

In spite of the progress made by the Ugandan government and explicit protections in the domestic and international laws including the convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)[43] violations still exist. Uganda has committed itself to ensure access to specific educational information to help ensure the health and well-being of families, including information and advice on family planning[44] to ensure, on a basis of equality of men and women, access to health-care services, including those related to family planning and to ensure appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where

[42] See for example, Vierdag, op.cit., note 37.

[43] Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), *adopted* Dec. 18, 1979, G.A. Res. 34/180, 34 U.N. GOAR, Supp. No. 46, at 193, U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981) (*ratified by* Uganda Jul. 22, 1985) [hereinafter CEDAW].

[44] Article 10(h) of CEDAW.

necessary[45] to take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure access to adequate health care facilities, including information, counseling, and services in family planning and to ensure to women the rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights[46].however violations are still rampant.

Lack of health care services

Though the Uganda Constitution does not provide expressly for the right to health it provides that the state is enjoined to take all practical measures to ensure the provision of medical services to the population.[47] This connotes that enjoyment of this right depends on how much the Government spends on health care. This is the reason as to why the maternal mortality ratio in Uganda is still at 430 maternal deaths per 100,000 live births[48]. Under the Millennium Development Goals, Uganda committed to reducing its maternal mortality rate to 132 deaths per 100,000 live births by 2015 .Given the current state of maternal health services in Uganda; it appears highly unlikely that the government will meet this commitment.[49]

For every maternal death in Uganda, six women suffer severe several disease such as anemia, infertility, pelvic pain, incontinence and obstetric fistula that lead to chronic and debilitating ill health and over 100 suffer at least one form of maternal morbidity. These devastating morbidities are caused, in part, by the majority of deliveries occurring outside of health facilities and without skilled attendance, and by delays in seeking and accessing care. Morbidity rates are also high within health facilities, indicating the limited capacity,

[45] Article 12 of CEDAW.
[46] Article 14 (2) (b) of CEDAW.
[47] Objective XX of the Uganda Constitution.
[48] Christabel Ligami "Plan Mooted To train 1500 Midwives in East Africa "September 22-28,2012 Page 30
[49] Report of World health organization (2002) under millennium development goals 2015.

resources, supplies and skills available to clinics and hospitals as well as the barriers in access to care[50] .

Access to, and quality of, delivery care is also a serious problem[51]. Although approximately half of all Uganda's health facilities offer basic delivery services, just 5% provide cesarean sections, and only one-quarter are able to provide minimum health services on a 24-hour basis[52] .The 2007 USPAS reveals that less than half of facilities are equipped with transportation for maternity emergencies, which creates a significant obstacle in obtaining emergency obstetric care, particularly for the 58% of women who give birth outside of a health facility [53].Less than half of facilities are equipped with the essential supplies to prevent infection during delivery, including soap, running water, disinfectant, and clean latex gloves .Just one-third of facilities carry the basic equipment for conducting normal deliveries including scissors, clamps, and a suction apparatus . Even those facilities that do carry supplies may be unable to properly sterilize instruments, with just 10% equipped with the requisite sterilization materials.

> According to Risdel Kasasira "*shortages are even more severe in the northern regions of Uganda: the government's failure to implement the Peace, Recovery and Development Plan for Northern Uganda (PRDP), which includes critical*

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[50] . P. Okong et al., *Audit of severe maternal morbidity in Uganda – implication for quality of obstetric care*, 85 ACTA OBSTET. GYNECOL. SCAND. 797-804 (2007).

[51] Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), *adopted* Dec. 18, 1979, G.A. Res. 34/180, 34 U.N. GOAR, Supp. No. 46, at 193, U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981) (*ratified by* Uganda Jul. 22, 1985) [hereinafter CEDAW]. , art. 12, para. 2.

[52] UGANDA, MINISTRY OF HEALTH, UGANDA SERVICE PROVISION ASSESSMENT SURVEY 2007 17-18 (2008), *available at* http://pdf.usaid.gov/pdf_docs/PNADM577.pdf [hereinafter 2007 USPAS]. at 26.

[53] UGANDA BUREAU OF STATISTICS, UGANDA DEMOGRAPHIC AND HEALTH SURVEY 2006 281 (Aug.2007)*available at* http://www.measuredhs.com/pubs/pdf/FR194/FR194.pdf [hereinafter UDHS 2006] at 125.

maternal healthcare objectives, reflects the ongoing marginalization and neglect of this region in terms of access to reproductive health services"[54].

In addition to the lack of supplies, inadequacies in the number of healthcare providers as well as the skill level of birth attendants pose a grave threat to maternal health. Approximately one half of health facilities are able to offer 24-hour delivery care by any type of trained medical provider, while just 5% have delivery protocols in place [55].In northern Uganda, just 35% of births are attended by any type of trained professional, and the number of skilled deliveries is the lowest in the country .A recent study showed that, of the health facilities expected to be able to offer basic emergency obstetric care (EMOC), fewer than 3% could do so[56] .Only 5% of births occur in facilities equipped for emergency obstetric care .One study showed that 86% of women who should have had some form of obstetrical intervention were unable to obtain it [57].

Of the few facilities that offer cesarean sections and other emergency procedures, just two-thirds are staffed with anesthetists .The majority of hospitals and other health facilities are unable to provide blood transfusions, which is a critical barrier to addressing the fact that one quarter of all maternal deaths are caused by severe bleeding without remedy[58] .
Each year an estimated total of 297,000 induced abortions (both legal and illegal) are performed in Uganda with approximately 1,200 women dying each year from unsafe

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[54]Risdel Kasasira, *Women left out in northern Uganda recovery* process, THE DAILY MONITOR, Jun. 19, 2010, *available at* http://www.monitor.co.ug/News/National/-/688334/941812/-/view/printVersion/-/st7u2r/-/index.html (accessed August 11, 23 2010).

[55] WOMEN'S COMMISSION FOR REFUGEE WOMEN AND CHILDREN & UNFPA, WE WANT BIRTH CONTROL: REPRODUCTIVE HEALTH FINDINGS IN NORTHERN UGANDA 11 (Jun. 2007), *available* at /http://www.unhcr.org/refworld/country,,WCR,,UGA,456d621e2,48aa831a0,0.html (accessed Aug. 11, 2010).

[56] A.K. Mbonye et al., *Declining maternal mortality ratio in Uganda: Priority interventions to achieve the Millennium Development Goal*, 98 INT'L J. OF GYNECOL. & OBSTET. 285, 289 (2007).

[57] V. Orinda et al., *A sector-wide approach to emergency obstetric care in Uganda*, 91 INT'L J. OF GYNECOL. & OBSTET. 285, 289 (2005).

[58] WHO, THE WORLD HEALTH REPORT 2005: MAKE EVERY MOTHER AND CHILD COUNT 62 (2005), *available at* http://www.who.int/whr/2005/whr2005_en.pdf.

abortions and nearly 85,000 women treated for complications[59] . Although there are no official statistics on abortion or abortion complications, it is clear that unsafe abortion is a leading cause of maternal morbidity and mortality in Uganda. A recent submission from Uganda to the All-Party Parliamentary Group on Population, Development and Reproductive Health puts the percentage of maternal deaths attributable to unsafe abortion at 26%[60] .

Right to give birth and spacing of children's

Women continue to be sidelined on decisions concerning child spacing and child bearing and this has hindered the realization of the reproductive rights. In the absence of contraceptive services, women may experience unwanted pregnancies, possibly resulting in death or illness due to lack of adequate healthcare, or they may seek out unsafe illegal abortions that can result in complications or death. Moreover, lack of contraceptive access affects women's right to control their fertility, the right to decide whether to have children and the number and the spacing of children, and the right to self-protection against sexually transmissible infections (STIs) including HIV/AIDS.

In spite of this, access to contraception is undermined by a number of factors, including an inadequate and inconsistent supply of contraceptives, financial barriers, and shortcomings in providing family planning information. As a result, the unmet need for family planning services in Uganda is 41%, according to the 2006 UDHS.[61] More recent data collected by the Guttmacher Institute shows that this unmet need for family planning skyrockets in the North, where socioeconomic disadvantage and unrest create additional barriers for women, leading to an 84% unmet need for family planning in the region.[62] Women continue to be

[59] SUSHEELA SINGH ET AL., UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA: CAUSES AND CONSEQUENCES 4, 6, 10 (AGI) (2006).

[60] UNFPA, MATERNAL MORTALITY UPDATE 2002: A FOCUS ON EMERGENCY OBSTETRIC CARE6(2003), *available at* http://www.unfpa.org/upload/lib_pub_file/201_filename_mmupdate-2002.pdf (accessed Aug. 16, 2010).

[61] *Ibid* at p. 30.

[62] ALAN GUTTMACHER INSTITUTE (AGI), IN BRIEF NO. 4, BENEFITS OF MEETING THE CONTRACEPTIVE NEEDS OF UGANDAN WOMEN 3 (2009), *available* at http://www.guttmacher.org/pubs/IB_Contraceptive-

restricted on their right to abortion or not as per section 212 and 213 of the Penal Code Act[63] thus denying them the right to decide on their procreative activities. The shortfall in family planning services means that Ugandan women on average have two more children than the number of children they desire hence violation of their reproductive right .[64]

Causes of Women Reproductive Rights Violations

Restrictive laws

According to Stigma Burris , *"law can be a means of preventing or remedying the enactments of stigma as violence, discrimination or any harm as well as it can be a medium through which stigma is created, enforced or disputed".*[65]

The researcher agrees that law can play a role in structuring individual resistance to stigma for example if the Anti-abortion laws are not repealed or the HIV bill , or anti-homosexuality bill 2009 is passed the individual with a signaled health condition acceptance of society view and self- stigmisation may lead to concealment to avoid discrimination. Repressive control of women's sexual and reproductive behavior manifests itself in many laws and policies.[66] Laws frequently criminalize access to medical procedures that only women need, such as abortion, and ignore the injustices that result from the biological fact that women bear the exclusive burden of unwanted pregnancy.

The most striking fact about maternal health in the world today is the extraordinary difference in maternal death rates between industrialized and developing countries. In the industrialized countries maternal deaths are now rare: the average life time risk for a

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Needs-Uganda.pdf (accessed August 5, 2010). (The methods used by the Guttmacher Institute to calculate unmet family planning needs differ from the UDHS methods by including women based on their childbearing intentions, as well as counting traditional contraceptive methods under the unmet need based on their proven high failure rates).

[63]Cap 120 .

[64] UDHS 2006, *supra*,30 at 107.

[65] Stigma Burris "stigma and the law" (2006) Lancet 529.

[66]Stephen L. Isaacs, *Reproductive Rights 1983: An International Survey*, 14 COLUM.HUM.RTS.L.REV. 311 (1982-83) (analyzing comparative law on reproductive rights).

woman dying of pregnancy-related causes is between 1 in 4,000 and 1 in 10,000. For a woman in the developing countries, the average risk is between 1 in 15 and 1 in 50. These countries commonly have maternal mortality rates 200 times higher than those of Europe and North America--the widest disparity in all statistics of public health.[67]

According to Cook, Dickens, and Fathalla[68] *"Unsafe abortion accounts for 60% of maternal death in some countries and approximately 13% of all the maternal death worldwide result from unsafe abortion."* Each year an estimated total of 297,000 induced abortions (both legal and illegal) are performed in Uganda with approximately 1,200 women dying each year from unsafe abortions and nearly 85,000 women treated for complications.[69] With percentage of maternal deaths attributable to unsafe abortion at 26%.[70]

Therefore though Uganda was commitment to improving maternal health, its abortion law and policies are characterized by restrictiveness and a lack of clarity. The Penal Code classifies abortion as a felony and criminalizes abortion except to save the life of the pregnant woman.[71]

The Ugandan constitution states that —no person has the right to terminate the life of an unborn child *except as may be authorized by* law.[72] Domestic judicial interpretation of abortion rights in Uganda has acknowledged that unsafe abortion is an infringement of women's rights as seen in the case of ***Ug v. Dr, Hassan Nawabul & Anor*** [73] that must be prevented and addressed, despite maintaining that abortion is illegal. Although Uganda

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[67] *Maternal Mortality Rates: A Tabulation of Available Data* at 2, WHO Doc. FHE/86.3 (2d ed. 1986), *cited in* Halfdan Mahler, *The Safe Motherhood Initiative: A Call to Action*, 1987 LANCET 668, 670.

[68] Reproductive Health and Human Right: in regrating medicine, Ethics and Law (oxford university press,2003)26.

[69] SUSHEELA SINGH ET AL., UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA: CAUSES AND CONSEQUENCES 4, 6, 10 (AGI) (2006) [hereinafter UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA].

[70] *Ibid.*

[71] Section 224 PENAL CODE ACT (CAP 120), LAWS OF UGANDA REVISED EDITION at 136-137 1995.

[72] REPUBLIC OF UGANDA CONST. art. 22(2) (1995).

[73] Crim. Case 562/08).

recently ratified the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), which supplements the African Charter and provides broad protections for women's human rights, the government reserved on Article 14(1)(a), which guarantees women the right to control their fertility.[74] The government further reserved on Article 14(2)(c), which would have expanded access to safe abortion services to include exceptions to preserve the woman's health and in cases of rape and incest.[75]

Uganda's National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights (Reproductive Health Guidelines) detail an expanded scope of circumstances permitting legal abortion, such as sexual violence and incest, and outline comprehensive abortion and post-abortion care standards.[76] In practice, however, doctors and other trained providers are reluctant to provide the comprehensive services outlined in the Guidelines, unwilling to be potentially subject to criminal liability under the Penal Code. Doctors may even refuse to perform post-abortion care, and women are likewise afraid to seek professional abortion-related care, for fear of being reported to the police.[77]

Attitude of the both policy makers and consumers

According to Ruth Dixon Mueller *et.al*[78]*. "Realization of reproductive rights depend on responsibilities on the part of stakeholders that include individuals, communities social institutions and more particularly the Government as the custodian of state resources and protection of collective interests"*

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[74] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), 32 (Jul. 11, 2003).

[75] *Ibid.*

[76] Republic of Uganda, Ministry of Health, the National Policy Guidelines and service standards for Sexual and Reproductive Health and Rights 4.13 (2006).

[77] Dr. Maria Nassali, legal assessment: Uganda, a legal and political analysis of abortion in Uganda, 34 (2010). At 14,19.

[78] Towards a sexual ethics of rights and responsibilities 17 REPRODUCTIVE HEALTH MAKERS 111(2009).

Majority of the people appear to be uncomfortable in discussing issues relating to sexuality and reproduction. This has resulted in poor and abject lack of information on reproductive rights and issues including policy makers at all levels. This in effect affects the global policies in place as such are frustrated and yet if they could be used at country level they would improve reproductive rights. The researcher believes that for there to be realization of women reproductive rights there is need for change of attitude of not only the policy makers, health care providers but also consumers.

Culture

Society in Uganda has been revolving around cultural traits. Despite global evolving and progress in our Cultures, men, in Uganda have neglected value beliefs which reduce their power and authority in a household. Social norms have since time memorial branded women as property of men. Hence men violate rights of women simply because, culturally they are the heads of families.[79] . The payment of bride price reduces a woman's status to that of property so that she is not entitled to own anything in the home. If the relationship is violent and she is attempting to leave, culture demands that she returns the bride price paid for her yet she cannot afford the refund since she cannot own any property. Bride price is a critical issue of our time because the majority of poor people in Africa are subject to customary law whose main tenet is the subordinate position of women and nowhere is this more apparent than in marriage. This subordination is underscored by the practice of bride price and yet marriage is the primary site for women's struggle for self determination and equality.[80]

In the Ugandan case of ***R* Vs *Amkeyo***, the judge in dismissing a petition for divorce, brought on the basis of cruelty concluded that a customary marriage was no marriage at all, but was something akin to wife purchase. Bride price affects a woman and acts to diminish their autonomy and sense of self worth. The payment is sometimes used to

[79] Buddle, Benninger Carin, Violence against Women, OMCT Gera, 2000.

[80] Balancing the scales: Addressing gender concerns in the collection, analysis and dissemination of Development Statistics – Trainers' Manual.

control a partners actions for example the right to decide on the number and spacing of the children, her rights on divorce and her independence. There are proposals in the Domestic Relations Bill that bride price should be made voluntary however it has taken years to be passed. [81]

The power to make decisions regarding health, reproduction, and children remains in the hands of men. This power imbalance poses increased health risks, including the risk of contracting HIV and other STIs, by depriving women of the power to negotiate condom use. [82] The Marriage and Divorce Bill, which includes provisions on equality in marriage and in the family, addresses women's right to negotiate sex on the ground of health would go a long way towards addressing these gender inequalities.[83] However, despite repeated attempts by women's groups to push for the bill's passage, Parliament has repeatedly shelved the bill and delayed the legislative process for almost two decades.[84]

Role of the religious institutions

Religion

When we consider reproductive rights as a central feature of women's human rights, as United Nations documents clearly and repeatedly have done, and then consider how reproductive rights are denied by the manner in which others "manifest their religion or belief in practice and teaching," it is really absurd. Muslims have also come up to advocate for family planning whereas it has been claimed that it is a way of killing Allah's people.[85] Sexual and Reproductive Health, Rights, & Religion: Partnerships for the Future" was a colloquium held on October, 15 2009 in partnership with the Population Council to

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[81] (1917) EA LR 14.

[82] UDHS 2006, *supra* note 88, at 246.

[83] Vanessa Von Struensee, The Domestic Relations Bill In Uganda: Potential For Addressing Polygamy, Bride Price, Cohabitation, Marital Rape, Widow Inheritance, And Female Genital Mutilation 2-3 (2008).

[84] *Ibid* page 1.

[85] Sheikh Ductoor , "stop the tradition of having swarm children" New Vision NewsPaper,30th September 2011 pg 9.

encourage dialogue and collaboration among the leaders of international faith-based groups and sexual and reproductive health and rights (SRHR) organizations.

The meeting was an opportunity to discuss how partnerships can be developed between faith-based groups and SRHR organizations to effectively and collaboratively address global reproductive and sexual health needs. The colloquium featured presentations that gave an overview of the issues and the role of both religious and secular organizations in response to improving the lives of girls and women. We also had the opportunity to learn from examples of existing partnerships between international health and education organizations with faith-based partners such as the United Nations Population Fund (UNFPA) initiatives to involve faith-based leaders in their work.

CHAPTER TWO

LEGAL AND INSTITUTIONAL REGIME OF WOMEN REPRODUCTIVE RIGHTS

Introduction

Human rights can be broadly divided into relative rights, such as sexual nondiscrimination rights, and inherent rights, such as the right to liberty and security of the person. The application of both inherent and relative rights ensures women's reproductive rights. The following analysis starts with the relative right to be free from all forms of discrimination, and then proceeds to an analysis of inherent rights to life, liberty, and security of the person, the right to marry and found a family, the right to private and family life, rights regarding information, education, and assembly, the right to reproductive health and health care, and the right to the benefits of scientific progress.[86]

The Right to Health in the Uganda Constitution

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

The Constitution of Uganda lacks a substantive provision on the right to health but makes mention of the right under other provisions. For instance, Objective XIV(b), which is found under the part concerning Uganda's national principles and objectives of national policy, sets out the State's duty to ensure that all Ugandans enjoy access to health services (Republic of Uganda, 1995). Objective XX expresses the State's commitment to take all practical measures to ensure the provision of basic medical services to the population. Article 39 affirms every Ugandan's right to a clean and healthy environment.[87] But also Under Article 21(2) of the Constitution provides that no one should be discriminated

[86] Objective XIV the Uganda Constitution of 1995 Section of the Constitution's National Objectives and Directive Principles of State Policy (NODPSP).

[87] Article 39 of 1995 Uganda constitution.

against.[88] Therefore, the State is required to protect women and their rights, taking into account their unique status and natural maternal functions.

The provisions of the Uganda constitution under Article 33(3), Children are protected under the Constitution.[89] Article 34(3) provides that no child should be deprived by any person of medical treatment,[90] while Article 34(4) provides that they are entitled to protection from social or economic exploitation and that they should not be employed in or required to do work that is likely to be harmful to their health.[91]

The Constitution also has provisions on restriction of rights to protect public health. Article 26(2) provides that a person can be deprived of property in the interest of public health.[92] Similarly, under Article 23(1) d, a person can be deprived of their personal liberty to prevent spread of an infectious or contagious disease.[93] The Constitution has some provision on the right to life. Article 21(1) provides that no person should be deprived of life intentionally except under the law in execution of a sentence passed in a fair trial by a Court of competent jurisdiction in respect of a criminal offence and if the conviction and sentence have been confirmed by the highest Appellate Court.[94] Article 22(2) provides that no person has the right to terminate the life of an unborn child, unless authorized by law.[95]

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

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[88] *Ibid* Article 21(2).
[89] *Ibid* Article 33(3).
[90] *Ibid* Article 34(3).
[91] *Ibid* Article 34(4).
[92] Article 26(2) the 1995 Constitution on the provisions on restriction of rights to protect public health.
[93] *Ibid* Article 23(1) d.
[94] *Ibid* Article 21(1).
[95] *Ibid* Article 22(2).

In 2005, a Constitutional amendment introduced Article 8A, a provision which strengthens the application of the NODPSP and affirms their legal status. Article 8A is important because it gives the objectives and principles full legal effect. This means that the objectives and principles can be used in litigation requiring the interpretation of the Constitution. Any reading of the Constitution should integrate the objectives and principles, which should also guide interpretation.[96]

It is important to note that the judicial enforceability of the objectives and principles was given effect to by the Constitutional Court of Uganda way back before the adoption of Article 8A. In the case of ***Salvatori Abuki and Anor v Attorney General,***[97] The Court endorsed an approach adopted by the Indian Supreme Court to the effect that elements of the NODPSP can be used in interpreting the Constitution.

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

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

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[96] Article 8A of the 2005 Constitutional amendment.

[97] The Constitutional Case No. 2 of 1997.

Rights of women (1) Women shall be accorded full and equal dignity of the person with men. (2) The State shall provide the facilities and opportunities necessary to enhance the welfare of women to enable them to realize their full potential and advancement. (3) The State shall protect women and their rights, taking into account their unique status and natural maternal functions in society. (4) Women shall have the right to equal treatment with men and that right shall include equal opportunities in political, economic and social activities. (5) Without prejudice to article 32 of this Constitution, women shall have the right to affirmative action for the purpose of redressing the imbalances created by history, tradition or custom. (6) Laws, cultures, customs or traditions which are against the dignity, welfare or interest of women or which undermine their status, are prohibited by this Constitution.[98]

The 1995 Constitution imposes obligations on private individuals to respect human rights. It provides that it is the duty of every citizen of Uganda to respect the rights and freedoms of others[99] and to protect vulnerable persons against any form of abuse, harassment or ill treatment.[100]

The Constitution further provides as follows,
The rights and freedoms of the individual and groups enshrined in this chapter [Four] shall be respected, upheld and promoted by all organs and agencies of Government and by all persons (emphasis mine).[101]

The word 'persons' includes natural and artificial persons. It can thus be argued that this constitutional provision moves accountability beyond the traditional focus on the state as sole protector of human rights.

The 1995 Constitution covers some of these rights. For example, it provides for the right to education,[102] the right to a clean and healthy environment,[103] women's rights,[104] and

[98] Article 33 of the 1995 Constitution.

[99] The 1995 constitution Article 17 (1) (b).

[100] *Ibid* Article 17 (1) (c).

[101] *Ibid* Article 20 (2).

[102] Article 30. Of the 1995 Uganda constitution.

minority rights.[105] However, the Constitution does not expressly provide for the right to health care. Because of this, some may argue that the right to health care is not justiciable in Uganda. Iain Byrne has correctly observed that non-cofidification of the right to health in domestic law is not necessarily a bar to its adjudication and enforcement by the courts.[106] Byrne points out that the lack of constitutional protection for health rights provides courts, lawyers and activists with significant but not insurmountable challenges for enforcement.[107]

The main legislation on the protection of public health is the Public Health Act.[108] It should be noted that although the protection of public health and human rights are aimed at the advancement of human well-being, there is always a potential tension between the two.[109] Human rights can be limited on grounds of protection of the public health. However, the Public Health Act adopts an approach that is antithetical to the protection of human rights. The Act provides for quarantine measures, compulsory notification and treatment.[110] A related legislation is the Venereal Diseases Act,[111] which enacts as follows,

> *Any medical officer of health may require any person who he or she knows or reasonably suspects to be infected with a venereal disease to submit him or herself for examination at such time and places as the medical officer of health may direct.*[112]

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[103] *Ibid Article 39.*
[104] Article 33.
[105] *Ibid Article 36.*
[106] Byrne *et al* (2005), 'Making the Right to Health a Reality: Legal Strategies for Effective Implementation'. A Paper Delivered at the Commonwealth Conference, London, September
[107] *Ibid (2005).*
[108] Cap. 281, Laws of Uganda.
[109] See, J. Mann et al (1999).
[110] See for example, Parts III-VIII of the Act.
[111] Article 43 of the 1995 Constitution provides for general limitation of human rights. One of the grounds of limitation is public interest, which includes protection of the public health.
[112] Section 2 of Cap. 284, Laws of Uganda.

The Constitutional Court Provisions

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

The Court of Appeal is followed by the High Court and subordinate courts which could include magistrate courts, courts martial, and local council courts. The right to petition the Constitutional Court is provided for in Article 137(3).

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

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

The fact of the case was as follows:

On 19th August 2009, Sylvia Nalubowa delivered a baby at Manyi Health Centre III, a government health care facility in Mityana. It was, then established that she was to have twins and required emergency obstetric care to deliver the second baby. The mother was referred to Mityana Hospital. Unfortunately, instead of leaving the hospital with the babies, Ms. Nalubowa was wheeled out in a coffin,

together with one of the babies. At the hospital, the attendant to the mother, now an emergency case, was first asked to pay for three bottles of rehydrating water, which she did, even when the facility was a government one.[113]

In the words of the attendant, Rhoda Kukkiriza, "at this time the deceased was in extreme pain and crying for help she bled to death, one of the twin babies still in her womb.

The Crux of Constitutional Petition No.16 of 2011. It is the tragic stories of Sylvia and Jennifer from which Constitutional Petition No. 16 of 2011 arises. In the petition, CEHURD and others state that the non-provision of basic indispensable health maternal commodities in government health facilities and the imprudent and unethical behavior of health workers towards expectant mothers are inconsistent with the Constitution and a violation of the right to health. Rampant maternal mortality is also caused by the government's non-provision of the basic minimum maternal health care packages, which constitutes a violation of the right to health.

Furthermore, the petition attributes the high maternal and infant mortality rate to the inadequate human resource for maternal health specifically midwives and doctors, frequent stock-outs of essential drugs for maternal health and lack of Emergency Obstetric Care (EmOC) Services at HC III, IV and hospitals. It is indicated that the inadequate financial and human resources, capital investment and management issues have resulted in the public sector being unable to fulfill its mandate of providing medicines and other essential maternal health commodities to meet the requirements of universal access to health care.[114]

The petitioners rely on a number of provisions of the law to make their case. This includes Objectives I (i), XIV (b), XXVIII (b), Articles 33(2) & (3), 20(1) & (2), 22(1) &(2), 24,

[113] The case of The Constitutional Petition 16 of 2011.

[114] Objective 1(i) xiv (b), xxviii (b) of the Constitution's National Objectives and Directive Principles of State Policy (NODPSP).

34(1), 44(a), 287, 8A and 45 of the constitution, provisions illustrated above. This is in addition to the provisions of the international treaties which Uganda has ratified, including the ICESCR, CEDAW and the ACHPR.[115]

Uganda Human Rights Commission

In addition to the formal courts, the human rights protected by the Constitution can be enforced in such institutions as the Uganda Human Rights Commission (UHRC) and the Equal Opportunities Commission (EOC). The UHRC is constituted by the Constitution (Article 51) and is mandated to among others, investigate the violation of any human rights. The Constitution (Article 53(1) empowers the Commission to exercise a number of judicial powers in discharging its functions. This includes issuing summons for attendance of persons or production of evidence, and is empowered to order, among others, any legal remedy or redress.

The National Health Policy

The overall objective of the *National Health Policy 2009* (NHP) is to ensure a good standard of health for all people in Uganda. In the policy, the state commits to the promotion of access to education, health services and clean and safe water. This is in addition to investing in and promoting people's health to ensure that they remain productive and contribute to national development. The policy deals with a number of issues, including determinants of health, organisation and management of the health sector; health service delivery; the public health delivery system; the role of the private and private subsectors; research, legislation and enforcement; health resources that include health supplies and human resources by looking into infrastructure and financing, strategies, monitoring and evaluation.[116] In accordance with the Constitution and the Local Government Act, the health sector shall continue operating a decentralised health service delivery system where

[115] Articles 33(2) & (3), 20(1) & (2), 22(1) &(2), 24, 34(1), 44(a), 287, 8A and 45 of the 1995 Uganda constitution.

[116] The *2009 National Health Policy* (NHP).

focus shall be on strengthening district health systems to deliver the UNMHCP including health promotion, disease prevention and One institution that can make the National Health Policy more effective is the religious institution which has traditionally played a role in setting up Hospitals and educational institutions for example Kibuli Hospital in Kampala and Mutolere Hospital in Kisoro are affiliated to religious organizations.

International Conference on Population and Development (ICPD) agenda, and attainment of Millennium Development Goals (MDGs) in Uganda. Critical areas identified for further improvement have been incorporated in the Seventh Country Programme. These include building capacity of national systems, strengthening results-based management and quickening business processes, and linking to national plans and policies. In addition, advocacy efforts need to target both communities and high-level policymakers. The call for tangible results is pronounced among programme implementers, development partners and target populations. Managing for results however requires both vertical accountability to the target populations and horizontal accountability within a partnership arrangement. This will ensure achievements are being assessed against tangible impact measures.

National Development Plan

The national development plan recognizes the role of health in National Development hence. The development of this National Health Policy (NHP II) has been informed by the National Development Program (NDP) for the period 2009/10-2013/14, the overall development agenda for Uganda. The NDP places emphasis on investing in the promotion of people's health, a fundamental human right for all people. Constitutionally, the Government of Uganda (GoU) has an obligation to provide basic medical services to its people and promote proper nutrition. The Constitution further provides for all people in Uganda to enjoy rights and opportunities and have access to education, health services and clean and safe water. Investing in the promotion of people's health shall ensure they remain productive and contribute to national development.[117]

[117] National Development Program (NDP) for the period 2009/10-2013/14.

the National Development Plan (NDP) which is an overall development strategy for the GoU that details priority interventions in any sector. The NDP explains how economic development exemplified by, for example, reduction in prevalence of poverty can be achieved. Economic development is dependent on social and human development. Improvement of people's health is both an outcome and a cause of economic development. The NDP prioritises the implementation of the UNMHCP. Currently, the health sector is implementing HSSP II which expires in 2010.

The policy and the strategic plans, which have been developed based on national development plans, have guided developments in health during this period. The NHP II has also been formulated within the context of the provisions of the Constitution of the Republic of Uganda (1995) and the Local Government Act (1997) which decentralised governance and service delivery. Following this, the MoH has devolved responsibilities to the districts for them to manage the delivery of health care and private hospitals. The supervision of the NRH and the RRH remains under the MoH headquarters.[118]

The Health Sector Strategic Investment Plan (HSSP)

Health Sector Strategic Investment Plan was formulated to guide investments in the health sector for the next five years (July 2010-June 2015).[119] The HSSP III provides an overall framework with the major aim of among others contributing towards the overall development goal of the Government in accelerating economic growth and reducing poverty as stated in the National Development Plan (NDP) 2010/11-2014/15. The HSSP III has identified key challenges facing Uganda's health system and makes commitment to address these. It also sets priorities and key areas on which to focus health investment in

[118] National Health Policy (2009) Reducing poverty through promoting people's health
[119] The *Health Sector Strategic Plan III 2010/11–2014/15* (HSSP III).

the medium term, for both public and private partners to contribute to the attainment of both the health sector goals and the national goals as outlined in the NDP.[120]

The most striking aspect of HSSP III when compared to its predecessors, HSSP I and HSSP II, is the express recognition that health is a human right and derives from international instruments. On maternal health care, the Policy acknowledges the fact that not much progress has been made with respect to Millennium Development Goal 5 (MDG 5) which requires states to improve maternal health.

The National Adolescent Health Policy

Reproductive health issues affecting adolescents are dealt with the Policy documents the commitment of the Government to integrate young people in the development processes. It complements all sectoral policies and programmes and defines structures and key target areas for ensuring that adolescent health concerns are mainstreamed in all planning activities.[121]

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

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

[120] National Development Plan (NDP) 2010/11-2014/15.
[121] The *National Adolescent Health Policy, 2004.*

(a) doubling the contraceptive use rate among sexually active adolescents; reducing first childbirth by half from 59% to 30% (the proportion of women who have their First child below 20 years); (b) raising the age of first sexual intercourse to 18 years from 16.7; (c) increasing the proportion of adolescents abstaining from sex before marriage increased by 30%; (d) increasing protection/safe sex among sexually active adolescent by 30%; (e) increasing practice of dual protection in sex (against both disease and pregnancy) among adolescents by 30%; (f) integrating post-abortion care in all health centres HCIV, HCIII, HCII, HCI and arranging appropriate primary health care facilities with emphasis on post abortion family planning counseling and services; (g) ensuring that pregnant school girls continue with education after they have delivered; and (h) reviewing abortion law with a view to improve the services.[122]

The National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights[123]

The policies address the need for explicit direction and focus, as well as to streamline the training and provision of reproductive health services. It provides a framework for guiding reform and development of a results oriented national reproductive health program. The Policy also seeks to make reproductive health programmes and services accessible and affordable to the majority of the target groups.[124]

The policy guidelines aim to promote reproductive health rights which it defines to include: the right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children; the right to information and means to make the decisions as stated above; the right to attain the highest standard of sexual and reproductive health; and the right to make decisions concerning reproduction, free of discrimination, coercion and violence. The priorities for reproductive health include: safe motherhood including breast feeding and nutrition, pre-natal care, safe delivery and post-natal care; information, education and counseling on reproductive health and sexuality; abortion and post-abortion care; family planning; and adolescent reproductive health.

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[122] The *National Adolescent Health Policy, 2004.*

[123] The (2006) National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights.

[124] *Ibid* (2006).

The Reproductive Health Policy

Like the Adolescent Policy, the Reproductive Health Policy details the need for proper adolescent health and lists a variety of services to be provided to adolescents, including family planning, emergency contraception, maternal health care, post-natal care, voluntary counseling and testing, post abortion care, and STI/HIV/AIDS care. This is in addition for support for the prevention and protection of harmful traditional practices such as female genital mutilation.[125]

One of the most explicit instruments protecting the reproductive health rights of women is the Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa. This instrument is drafted in a manner that protects the rights of women from an African perspective. This includes the Protocol on the Rights of Women in Africa Article 14, Health and Reproductive Rights which states that:

> *1. States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes: a) the right to control their fertility; b) the right to decide whether to have children, the number of children and the spacing of children; c) the right to choose any method of contraception; d) the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS; e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices; the right to have family planning education. 2. States Parties shall take all appropriate measures to: a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas; b) establish and strengthen existing pre - natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breastfeeding; c) protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy*

[125] Center for Reproductive Health and FIDA Uganda, 2011. *Reproductive Health in Uganda: A Shadow Letter and Summary of Concluding Observations.*

endangers the mental and physical health of the mother or the life of the mother or the foetus.[126]

Piloting HIV Prevention is Unreasonable in South Africa

In South Africa, the Constitutional Court ***Minister of Health and Others v Treatment Action Campaign of 2002*** condemned as unreasonable a government programme for the provision of Neviripine, a drug that prevented mother-to child transmission of HIV.[127]

The Prohibition of All Forms of Discrimination against Women (CEDAW)

The Women's Convention characterizes the problem of women's inferior status and their oppression not just as a problem of inequality between men and women, but rather as a function of discrimination against women as such. The Convention is intended to be effective to liberate women to maximize their individual and collective potentialities, and not merely to allow women to be brought to the same level of protection of rights that men enjoy. It goes beyond the goal of sexual nondiscrimination, as required by the U.N. Charter[128], the Universal Declaration[129] and its two implementing Covenants[130] and the three regional human rights treaties,[131] to address the disadvantaged positions of women.

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[126] Article 14 of Health and Reproductive Rights of the Protocol on the Rights of Women in Africa.

[127] *Minister of Health and Others v Treatment Action Campaign of 2002.*

[128] *U.N. CHARTER arts. 13(1) (the General Assembly shall initiate studies to promote international economic and social co-operation without distinction as to sex), 55(c), 56 (the U.N. and its members shall promote respect for international economic and social co-operation without distinction as to sex).*

[129] *Universal Declaration, art. 2.*

[130] *Political Covenant, art. 2(1) (obligation to respect rights recognized without distinction as to sex), art. 3 (equal rights of men and women with respect to the rights recognized in the Covenant), art. 4 (measures derogating from the obligations cannot involve discrimination on grounds of sex), art. 14 (equality before the law), art. 23 (equality of rights and responsibilities of spouses as to marriage, during marriage and at its dissolution), art. 24 (equal protection of the child irrespective of sex). Economic Covenant, supra note 28, art. 2(2) (obligation to respect rights recognized without distinction as to sex), art. 3 (equal rights of men and women with respect to the rights recognized in the Covenant).*

[131] *European Convention, supra note 29, art. 14. American Convention, supra note 30, art. 1; African Convention, supra note 31, art. 2.*

A. S. v. Hungary[132]

A similar case was recently brought before the CEDAW Committee against the Government of Hungary on behalf of a Hungarian Roma woman who was sterilized without her informed consent. In *A. S. v. Hungary,* advocates relied upon CEDAW's explicit protection of women's right to health under Article 12.[133]

> *" A.S. was a pregnant Hungarian woman of Roma origin, who, on 2 January 2001, was taken by ambulance to a public hospital because she was experiencing labour pain, her amniotic fluid had broken and she was bleeding heavily. When she arrived at the hospital, A. S. was dizzy, still bleeding heavily and in a state of shock. The attending physician informed A. S. that the foetus had died in her womb and that an immediate caesarean section was necessary. While on the operating table, A. S. was asked to sign a consent form, as well as a barely legible hand-written note that read: "Having knowledge of the death of the embryo inside my womb I firmly request my sterilization [a Latin term unknown to the author was used]. I do not intend to give birth again; neither do I wish to become pregnant."*[134]

> *B. Hospital records confirm that the caesarean, the removal of the dead foetus and placenta, and the sterilization occurred within seventeen minutes of A. S.'s arrival at the hospital.*[135]

A. S. learned the meaning of the term "sterilization" only upon her departure from the hospital when she asked the doctor when she could have another baby. She later confirmed that she would never have agreed to the procedure. As a result of being sterilized, A. S. fell into a depression for which she was medically treated. After failing to obtain relief from the Hungarian courts, advocates submitted a communication to the

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[132] See *A. S. v. Hungary,* United Nations Committee on the Elimination of Discrimination against Women, Communication No. 4/2004, U. N. Doc. CEDAW/C/36/D/4/2004 (2006) (hereinafter *A. S. v. Hungary*).

[133] Article 12 of CEDAW establishes that states parties must "take all appropriate measures ... in the field of health care.

[134] *A. S. v. Hungary, supra* note 27, paras. 2.2, 2.3.

[135] See ibid. at para. 2.3.

CEDAW Committee, alleging violation of A. S.'s rights to access to information and advice on family planning,[136] to access health care services, including services in connection with pregnancy,[137] and to freely and responsibly decide on the number and spacing of her children.[138] The Committee found that Hungary had failed to provide, through hospital personnel, appropriate information and advice to A. S. on family planning.[139]

Therefore, Hungary failed to ensure this right. The Committee also found that by failing to ensure that A. S. provided her "fully informed consent" to be sterilized, Hungary violated A. S.'s right to access health care services, including those in connection with pregnancy.

In contrast to previous human rights treaties, the Women's Convention frames the legal norm as the prohibition of all forms of discrimination against women as distinct from the norm of sexual nondiscrimination.[140]. Uganda is party and signatory to the CEDAW which implies that, it supports to uplift the status of women to a level equal to their male counterparts in all spheres as upheld by the Constitution.[141] The convention provides the basis for realization of equality between women and men through allowing for equal access to and equal opportunities in political and public, education, health and employment. Reflecting on the effort of CEDAW in 1985, this law was devised as a way of ensuring that states take legal steps to protect women reproductive rights. Under the committee of CEDAW it was recommended that states to protect women from human rights violation through; creating education programmes that can change attitudes concerning roles and status of women and giving women access to public information.

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[136] See CEDAW, *supra* note 3, at Article 10(h).
[137] See *ibid.* at Article 12.
[138] See *ibid.* at Article 16(1)(e).
[139] See *A. S. v. Hungary, supra* note 27, at para. 11.2.
[140] *See generally* Anne F. Bayefsky, *The Principle of Equality or Non- Discrimination in International Law*, 11 HUM.RTS.L.J. 1 (1990).
[141] The Constitution of the Republic of Uganda Article 21(1).

CEDAW Committee Rules Against Brazil for Delayed Service[142]

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

This argument was supplemented by another based on Article 12 of CEDAW, which requires states to take all appropriate measures to eliminate discrimination against women in the field of health, which includes appropriate services in connection with pregnancy, confinement and the post-natal period[143]. The petitioner argued that the state failed to secure these services for the deceased, and that that medical staff had failed to detect in good time the death of the foetus, when birth was induced, at which point an immediate operation should have been carried out to remove it. Curettage surgery had been performed only after 14 hours. The Committee found the state to be in violation of the right to life and health. The conduct constituting the violation was found to include: the failure to detect the death of the foetus; carrying out curettage surgery a whole 14 hours after induction, at a health centre that did not have equipment; late transfer to a referral hospital; and failure to attend to her at the referral hospital where she waited in a makeshift area for 21 hours before she died.

[142] *Maria de Lourdes da Silva vs Brazil* delivered in July 2011.
[143] Article 12 of CEDAW.

While referring to its General Recommendation No. 28 (2010), the Committee noted that the lack of appropriate maternal health services in the State Party that fails to meet the specific, [144]distinctive health needs and interests of women not only constitutes a violation of Article 12(2)[145] but also discrimination under Article 12(1). In the opinion of the Committee, this is because the lack of appropriate maternal health services has a differential impact on the right to life of women.[146]

In a similar, the Indian High Court finds state government in violation of the right to life

In the case ***S.K. Garg vs. State of U.P. of 1998***, the High Court of Allahabad received a constitutional petition raising concerns about the pitiable nature of services in public hospitals in Allahabad. The Petitioner complained about the inadequacy of blood banks, worn down X-ray equipment, unavailability of essential drugs and unhygienic conditions at health facilities in the area. According to the Court, it was indeed true that most of the government hospitals in Allahabad were in a very bad shape and need drastic improvement so that the public is given proper medical treatment. The court took note of the distressing sanitary and hygienic conditions in government hospitals in Allahabad, where poor people are particularly not properly attended to. This was found to be a violation of the right to life.

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

[144] General Recommendation No. 28 (2010).
[145] Article 12(2).
[146] Article 12(1).

observed that providing adequate medical facilities is an essential part of the obligation undertaken by the State in a welfare state.[147]

Finally, Uganda's healthcare facilities are in a dire state, and maternal health is one of the most affected services. The incidents leading to Constitutional Petition No. 16 of 2011 are an epitome of a widespread systemic problem. The petition demonstrates that many maternal deaths are preventable if the state takes its human rights obligations seriously. Reproductive health as a human right is protected by both international and domestic law. It is important that these provisions are enforced and remedies obtained whenever the state is found to be in violation. This is what Constitutional Petition No. 16 seeks to do. The right to health has been the subject of judicial enforcement in cases across the globe. Even before judgment is handed down, Constitutional Petition No. 16 has already highlighted the systemic violation of the reproductive health rights of women, arising from both unethical neglect and the lack of essential medicines and facilities.[148] The petition has generated public debate on maternal health and rallied civil society advocates behind the cause of reproductive health. Although, at this stage one could argue that the case has already made an important impact, the problem of poor maternal healthcare is still a major issue and yet a lot of the maternal deaths are preventable.

[147] *Paschim Banga Khet Mazdoor Samiti vs. State of W.B.* of 1996.
[148] Constitutional Petition No. 16.

CHAPTER THREE

RESEARCH METHODOLOGY

This area looked at the method of tools in relations to An Examination of The Emerging Legal practices in Uganda. This part presented a description and explanation of procedures used in conducting the study, particularly in sampling and data collection. Qualitative was used to collect from sample population earmarked for the study.

Research Population

The study population consisted of Doctors, Midwives, traditional birth attendants, women rights activists and policy makers in the Uganda. The study population was divided into two (2) categories. Officers engaged in the provision of Reproductive health services in the first category; the second category was consisted of policy makers and women rights activists.

Sample Size

Purposive sampling design was used to derive sample from officers in the first category who were considered to be knowledgeable on the subject in question.

The sample size of 100 respondents were chosen and this included; 40 traditional birth attendants , 10 policy makers, 20 Human Right Activists, and picked doctors, 10 women rights activists. The responses got from these respondents were generalized to the whole population.

Sampling Procedure

The sample was a representation of the population. In other words most characteristics of the population should be represented in the selected sample. This was suitable sampling strategy. The procedure adopted ensured that the selected sample represents the population. This was clearly explained.

Data collection

This involved the collection and review of relevant documentation on the study there are rich documentation on women reproductive health in Uganda and other countries. Data to be exploited would include:

Unpublished reports/ records; the archives of opposition parties

Published reports (research studies/ Case studies and so on);

Conference abstracts, poster presentations and materials.

Newspaper articles, other media coverage;

Information accessed through the Internet;

Personal memoirs if any;

Any other authentic available sources of information that are documented

The procedure for data gathering includes the Researcher visiting major hospitals, sub-health centers and NGO's. The visits to health centers and records revealed the existing health facilities in terms of adequacy, equipment and the overall readiness to provide reproductive health services. In effect face to face interviews were held with staff of NGO's and health facilities about what they perceive in regard to the subject of study. Thus the face to face interviews were primarily guided by a list of open–ended and inter- locking questions related to various issues relevant to the study.

In this part of the study, the collection of data step by step, before, during and after the administration of the research instrument should be described.

Ethical Consideration

Respect for the views of the respondents, harm (physical and emotional harm). During the process of data collection, confirmation was given to the respondents in that the researcher assured the respondents that the reason for the research is for only academic purpose and that no information gave out outside .

Validity and Reliability of the Instrument

The interview guide (instruments) was pre-tested on a section of respondents who are not included in the sample. This assisted in testing the validity and reliability of the instruments. Furthermore consultations were made with Kampala International University supervisors to test further validity of the instruments.

Ethical Considerations

The researcher obtained respondents informed consent before interviewing them and the information obtained was for the purpose of the research project and treated with utmost confidentiality.

Limitations of the Study

The study is not only about what the law is, but also about what the law is ought to be. On what the law is, there are a number of materials, albeit not quite sufficient in the legal context. Hence this is one limitation which the study overcomes it.

On what the law is supposed to be, there are even fewer materials in the context of the law, though there are plenty of materials in other contexts for example the medical aspects. This is another limitation that the researcher strived to overcome.

There is also a cultural limitation; women of Uganda origin are not forthcoming on issues of reproductive rights.

CHAPTER FOUR
ASPECTS OF THEORY, PRACTICE AND LEGAL FRAMEWORK ON WOMEN REPRODUCTIVE RIGHTS

Introduction

Law is increasingly being recognized and used as a tool for improving the health of populations at global, national and sub-national levels. As a means of public health improvement, public health law focuses on the power and duties of the state to create the conditions for people to live healthy lives in ways that are consistent with human rights and liberties, and with due regard to other public interests and values that are acknowledged in society.

Efficacy of the Law on Women's Reproductive Rights

Not only have there been advancements in the realm of the right to health but a new generation of advocacy initiatives challenging reproductive rights violations is seeking to further bolster and clarify the human right to health. These initiatives include broader and more targeted allegations to further expand human rights interpretations and recognition of women's reproductive rights. They also seek to solidify a global understanding that access to quality reproductive health care is in fact a human right and one which is necessary to ensure protection of other rights such as the rights to life, health and equality and non-discrimination.

On 26-28 April 2009, the International Development Law Organisation (IDLO) hosted a consultation on public health law at IDLO headquarters in Rome, Italy. The consultation was co-sponsored by the World Health Organisation (WHO) and by the O'Neill Institute for National and Global Health Law at Georgetown University, Washington D.C. Twenty-two experts in public health law attended the consultation, in their personal capacities. The participants came from a wide range of countries and development agencies including: Australia, Canada, China, Egypt, Kyrgyzstan, Malawi, the Netherlands, South Africa, Uganda, the United Kingdom, the United States, Venezuela, the United Nations University,

the Food and Agricultural Organisation (FAO), the World Bank, the United Nations Development Program (UNDP), UNAIDS, together with the sponsors: IDLO, WHO, and the O'Neill Institute.

On November 25, 2005, the Protocol on the Rights of Women in Africa[149] (the protocol) entered into force, after being ratified by 15 African governments. Two years earlier, in July of 2003, the African Union—the regional body that is charged with promoting unity and solidarity among its 53 member nations—adopted this landmark treaty to supplement the regional human rights charter, the African Charter on Human and Peoples' Rights (the African Charter)[150]. The protocol provides broad protection for women's human rights, including their sexual and reproductive rights.

The significance and potential of the protocol go well beyond Africa. The treaty affirms reproductive choice and autonomy as a key human right and contains a number of global firsts. For example, it represents the first time that an international human rights instrument has explicitly articulated a woman's right to abortion when pregnancy results from sexual assault, rape, or incest; when continuation of the pregnancy endangers the life or health of the pregnant woman; and in cases of grave fetal defects that are incompatible with life. Another first is the protocol's call for the prohibition of harmful practices such as female circumcision/female genital mutilation (FC/FGM), which have ravaged the lives of countless young women in Africa.

Sub-Saharan Africa has the worst indicators of women's health—particularly of reproductive health of any world region. These indicators include the highest number of HIV-positive women and the highest infant, maternal, and HIV-related death rates

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[149] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2nd Ordinary Sess., Assembly of the Union, *adopted* July 11, 2003 [hereinafter Protocol on the Rights of Women in Africa].

[150] As of February 17, 2006, Benin, Cape Verde, Comoros, Djibouti, Gambia, Lesotho, Libya, Malawi, Mali, Mauritania, Mozambique, Namibia, Nigeria, Rwanda, Senegal, South Africa and Togo have ratified the Protocol.

worldwide. The ability of a woman to make her own decisions regarding her body and her reproductive life are key to improving these indicators. The protocol that advocates matters of health pressure governments to address the underlying social, political, and health-care issues that contributes to the dismal state of women's health throughout the continent.

The charter recognizes and affirms women's rights in three provisions. First, article 18(3) requires states parties to "ensure the elimination of every discrimination against women and also ensure the protection of the rights of the woman."[151] Second, article 2 provides that the rights and freedoms enshrined in the charter shall be enjoyed by all, irrespective of race, ethnic group, color, sex, language, national and social origin, economic status, birth or other status.[152] Third, article 3 of the African Charter states that every individual shall be equal before the law and shall be entitled to equal protection of the law.[153] And yet the protocol notes that "despite the ratification of the African Charter ... women in Africa still continue to be victims of discrimination and harmful practices."[154] The protocol, which resulted from years of activism by women's rights supporters in the region, has attempted to reinvigorate the African Charter's commitment to women's equality by adding rights that were missing from the charter and clarifying governments' obligations with respect to women's rights.

Existing global human rights standards recognize women's right to "the highest attainable standard of health"[155] and to equality in "access to health care services, including those related to family planning."[156] Among the current global human rights treaties, women's

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[151] African (Banjul) Charter on Human and Peoples' Rights, June 27, 1981, O.A.U. Doc. CAB/ LEG/67/3 rev. 5, 21 I.L.M. 58, art. 18(3) (1982) (*entered into force* Oct. 21, 1986) [hereinafter. African Charter].
[152] *Ibid.* art. 2.
[153] *Ibid.* art. 3.
[154] *See Ibid.* pmbl.
[155] Convention on the Rights of the Child (CRC), *adopted* Nov. 20, 1989, G.A. Res. 44/25, Annex, U.N. GAOR, 44th Sess., Supp. No. 49, at 167, art. 24(1), U.N. Doc. A/44/49 (1989) (*entered into force* Sept. 2, 1990).
[156] CEDAW, *supra* note 26, art. 12(1).

right to family planning is expressly recognized only in CEDAW and the CRC.[157] CEDAW additionally guarantees women's right to "appropriate services in connection with pregnancy";[158] and to "decide freely and responsibly on the number and spacing of their children, and to have access to the information, education and means to enable them to exercise these rights."[159] The CRC affirms women's right to "necessary medical assistance and health care";[160] to "appropriate pre-natal and post-natal health care for mothers";[161] and to "family planning education and services."[162]

One area in which women have always excelled in traditional African societies is in health, especially reproductive health. Apart from being the protectors of cultural traditions, customs and beliefs, women were also the preservers of indigenous knowledge related to herbal medicine and spirituality. Women were involved in childbirth, gynecological treatments, cosmetic treatments, and massage techniques for expectant women. Midwives and birth attendants knew the right diet for pre-natal and post-natal mothers. In view of the distances to health centers and the fact that traditional birth attendants and herbalists live close to the people it makes sense for them to be equipped in order to deal with health challenges which face women. A reconfiguration of the role of traditional birth attendants, being undertaken in Kenya, Tanzania and Uganda, could help reduce maternal mortality rates.

The CEDAW Committee considered the combined fourth, fifth, sixth and seventh report of Uganda (CEDAW/C/UGA/4-7) at its 954th and 955th meetings, on 13 October 2010[163]. The Committee welcomes the progress achieved since the consideration of the State party's third periodic report in 2002 (CEDAW/C/UGA/3), including the legislative reforms

[157] *See id.*; CRC, *supra* note 26, art. 24(2)(f).
[158] CEDAW, *supra* note 26, art. 12(2).
[159] *Ibid.* art. 16(1)(e).
[160] CRC, *supra* note 26, art. 24(2)(b).
[161] *Ibid.* art. 24(2)(d).
[162] *Ibid.* art. 24(2)(f).
[163] CEDAW report October 2010

that have been undertaken and the adoption of a wide range of legislative measures. Specific reference is made to:

a) The Land Act Amendment (2004); b) The Employment Act (2006); c) The Equal Opportunities Commission Act (2007) which provides a legal basis to challenge laws, policies, customs and traditions that discriminate against women, as well as the National Equal Opportunities Policy; d) The amendments to the Penal Code prohibiting defilement of girls and boys (2007); e) The Domestic Violence Act 3 (2010), criminalizing violence in a domestic setting; f) The Prohibition of Female Genital Mutilation Act 5 (2010); g) The Prevention of Trafficking in Persons Act (2010); and h) The International Criminal Court Act (2010), criminalizing sexual exploitation of women during conflict situations.

There has been progress on Constitutional Court rulings that have declared parts of existing legislation unconstitutional for being discriminatory against women, including the cases of the ***Uganda Women Lawyers Association v. Attorney General*** (2003) and the ***Law and Advocacy for Women in Uganda v. Attorney General*** (2006). While welcoming the efforts of the State party to achieve legislative reform, specifically in the context of the work of the Law Reform Commission, the Committee reiterates its concern at the low priority given to comprehensive legal reform to eliminate sex-discriminatory provisions and to close legislative gaps in order to bring the country's legal framework fully into compliance with the provisions of the Convention and to achieve women's *de jure* equality.

There have been big strides made on the enactment and immediate implementation of laws like the enactment of the 2010 Prohibition of Female Genital Mutilation Act. This Act made it illegal for anyone to get involved in mutilating women and this has helped reduce cases of FGM which has been dominant among the Sabins in the North East of Uganda. The customary practice of female genital mutilation is against the rights of women in most communities since it affects the pride of women and sometimes such rituals are performed by force

CHAPTER FIVE

CHALLENGES TO FULL REALIZATION OF WOMEN REPRODUCTIVE RIGHTS

Introduction

This chapter presents the challenges of Women Reproductive Rights in Uganda in access to medical and other health related rights. In reviewing the legislations and related documents in legal practices.

The constitution of the republic of Uganda guarantees the right to life[164] though historically the right has been applied only to prohibit governments from imposing capital punishment in an arbitrary manner, recent developments indicate that the right to life has been applied to matters of health and human dignity. The most obvious human right violated by avoidable death in pregnancy or childbirth is a Woman's right to life itself. Article 6.1 of the Political Covenant provides that "every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life."[165]

The Human rights committee explained that the expression 'inherent right to life' in article 6(1) of the ICCPR should not be understood in a restrictive manner, and the protection of this right requires the state to adopt positive measures such as those required to reduce infant mortality and life expectancy[166] This right is traditionally referred to in the immediate context of the obligation of states to ensure that courts observe due process of law before capital punishment is imposed.[167] This understanding of the right to life is essentially male-oriented, since men consider state execution more immediate to them than death from pregnancy or labor. It ignores the historic reality of women, which persists in regions of the world where almost all of the 500,000 women who die each year

[164] Uganda Constitution 1995 (as amended) Art.22(1) .

[165] This article reflects Article 3 of the Universal Declaration, and is given further effect in, for instance, Article 2 of the European Convention, , Article 4 of the American Convention on Human Rights , and Article 4 of the African Charter.

[166] General Comment No.6,UN.GAOR, 16th Sess.Annex 5,Supp.No.40, UN.Doc.A37/40(1982).

[167] PAUL SIEGHART, *THE INTERNATIONAL LAW OF HUMAN RIGHTS* 128-34 (1983).

from pregnancy related causes[168] live, and is indeed a focus of sex stereotyping in that capital punishment cannot usually be applied to pregnant women.

From the preceding analysis it is quite clear that legally, women have a right to health care, including access to ART. However, protection of the right is hampered by a number of internal and external constraints that cut across the legal and political spectrum. Some of these constraints affect the state's capacity to protect the right to health generally and the right to health care of WLA in particular. Others directly impact on the ability of WLA to access and utilize ART. Below, I present a discussion of the major constraints affecting protection of the right.

The strongest defense of individual integrity under the Political Covenant exists in article 9(1), which provides that "everyone has the right to liberty and security of their person.... No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law."[169] This right would seem to serve the state's negative interest of noninterference in an individual's pursuit of means to limit, or to promote, fertility.[170] Hence, it recognizes a woman's right to reproductive choice as an element of her personal integrity and autonomy, and not in any way solely dependent on health justifications. Further according to article 23 of the Constitution a person's right to personal liberty is protected.[171] This right can be extended to defend a woman's integrity, autonomy and self- determination in the matters of reproductive rights especially reproductive health.

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[168] *Maternal Mortality Rates: A Tabulation of Available Data* at 2, WHO Doc. FHE/86.3 (2d ed. 1986), *cited in* Halfdan Mahler, *The Safe Motherhood Initiative: A Call to Action*, 1987 LANCET 668, 670.

[169] G.A.Res. 2200, U.N. GAOR, 21st Sess., Supp. No. 16, at 52, U.N.Doc. A/6316 (1966) [*hereinafter* Political Covenant] art.4(1).

[170] Art.3 of the G.A.Res. 217, U.N.Doc. A/810, at 71 (1948) [*hereinafter* Universal Declaration].

[171] Supra note No.2 UDHR.

The Legal Framework:

International human rights law accentuates the adoption of legislative measures as one of the major means through which rights enshrined in various human rights instruments can be realized in the domestic arena.[172] Although the CESCR recognizes that each state has a margin of discretion in assessing the apposite feasible measures for implementing the right to health, it enjoins states to consider adopting a framework law to operationalize the right.[173] Such a law should include, inter alia, provisions on the targets to be achieved, the time frame for their achievement, and the means by which the right to health benchmarks could be achieved.[174] In Uganda, there is no law that specifically deals with the right to health and its components like the right to health care of WLA. None of the international and regional human rights instruments that recognize the right to health have been directly incorporated into the domestic legal system. The available legislation is either outdated and outmoded or piecemeal and simply inadequate in ensuring protection of the right to health generally and the right to health care of WLA in particular. Most of the issues concerning WLA are covered under policies, which are not legally binding.

The main legislation on the protection of public health is the Public Health Act.[175] It should be noted that although the protection of public health and human rights are aimed at the advancement of human well-being, there is always a potential tension between the two.[176] Human rights can be limited on grounds of protection of the public health.[177] However, the Public Health Act adopts an approach that is antithetical to the protection of human rights especially those of PLHA. The Act provides for quarantine measures, compulsory notification and treatment.[178] A related legislation is the Venereal Diseases Act,[179] which

[172] See for example, Article 2(2) of the ICESCR.
[173] Para. 53 General Comment 14.
[174] *Ibid.*
[175] Cap. 281, Laws of Uganda.
[176] See, J. Mann et al (1999).
[177] Article 43 of the 1995 Constitution provides for general limitation of human rights. One of the grounds of limitation is public interest, which includes protection of the public health.
[178] See for example, Parts III-VIII of the Act.
[179] Cap. 284, Laws of Uganda.

enacts as follows, Any medical officer of health may require any person who he or she knows or reasonably suspects to be infected with a venereal disease to submit himself or herself for examination at such time and places as the medical officer of health may direct.[180]

Furthermore, a violation occurs when a state's laws allow husbands or male partners to veto wives' or female partners' use of birth control. In at least eight countries, as well as in a regional human rights tribunal, courts have rejected applications by husbands or boyfriends for judicial prohibition of specific abortions.[181] Likewise, parental veto laws can be condemned when they obstruct personal choices of mature or emancipated minors who are able to make their own sexual decisions, and bear the consequences of such choices.[182] Paternalistic control of women's sexual and reproductive behavior has a history that reaches back into antiquity.[183] The limitations imposed by international human rights instruments on restrictive laws against women's choices have not been explored in a comprehensive or adequate way for example women are imprisoned for terminating their own pregnancies. Women may end up being un-appropriately charged for such offences if they lacked access to contraceptive services. For example in Uganda, abortion is outlawed under Section 141 of the Penal Code Act[184] which punishes a person who helps a pregnant woman to abort and further punishes a woman who aborts.[185] Another related offence is provided for under Section 143 of the Penal Code Act[186] which makes it unlawful to kill an

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[180] Sec. 2.

[181] U.S.: *Planned Parenthood v. Danforth*, 428 U.S. 52, 69 (1976) (held by a majority that the State of Missouri "may not constitutionally require the consent of the spouse ... as a condition for abortion....").

[182] *Gillick v. West Norfolk and Wisbech Area Health Authority*, 3 All E.R. 402 (H.L.1985) (parents' attempt to enjoin their minor daughter from having an abortion rejected).

[183] Roger Schofield, *Did the Mother Really Die? Three Centuries of Maternal Mortality in 'The World We Have Lost', in* THE WORLD WE HAVE GAINED: HISTORIES OF POPULATION AND SOCIAL STRUCTURE (Lloyd Bonfield *et al.* eds., 1986).

[184] CAP 120,Laws of Uganda.

[185] *Ibid section142.*

[186] *Ibid.*

unborn child, yet abortion is the surest way of contraception. The restrictive abortion laws and policies may for example be said to be inconsistent with women's right to liberty.[187]

The Act makes it mandatory for the person infected with a venereal disease to name the person who infected him or her.[188] Given that in Uganda, HIV infection is largely through heterosexual contact, the foregoing provisions may be employed by an overzealous medical officer against PLHA in utter violation of their right to privacy and human dignity.

Other pieces of legislation that have a bearing on protection of the right under inquiry deal with drugs and the regulation of medical practice. The Food and Drugs Act,[189] prohibits the preparation and sale of injurious and adulterated drugs. The Pharmacy and Drugs Act[190] regulates the pharmacy profession and trade in and use of drugs and poisons. The National Drug Policy and Authority Act[191] establishes the National Drug Authority, whose mandate includes 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.[192] The National Medical Stores Act[193] establishes the National Medical Stores, which is charged with the efficient and economic procurement, storage, administration, distribution and supply of medicines and other related goods.[194] These pieces of legislation, if implemented are critical in ensuring that ARVs and other drugs for treatment of opportunistic infections are safe and effective. However, the legislation does not spell out the specific targets that must be met and the benchmarks against which the state's performance and accountability may be weighed.

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[187] Art. 22(2) of the Uganda Constitution and Penal Code Act.
[188] Sec. 4 (1).
[189] Cap.278, Laws of Uganda.
[190] Cap. 280, Laws of Uganda.
[191] Cap. 206, Laws of Uganda.
[192] Sec. 3 and 5.
[193] Cap. 207, Laws of Uganda.
[194] A scandal has recently hit the National Medical stores whereby huge amounts of ARVs expired due to negligence. See, B. Simson & H. Nabayunga, 'Health probes ARV expiry', The Daily Monitor, Sept. 8, 2006, at 6.

The Medical and Dental Practitioners Act[195] governs the law relating to medical and dental practice. The Act establishes a Medical and Dental Practitioners Council whose functions include the general supervision and disciplinary control over medical and dental practitioners.[196] Other relevant functions include the protection of society from abuse of medical and dental care and research on human beings.[197] The Council is also charged with the responsibility of disseminating to the medical and dental practitioners and the public, ethics relating to doctor-patient rights and obligations.[198] According to the Act, a registered practitioner may demand reasonable charges for any treatment rendered, or for any drugs prescribed or supplied and shall be entitled to sue for or recover the same, with full costs in any court of competent jurisdiction.[199]

However, there are no guidelines as to what amounts to 'reasonable charges' forall drugs and services including ART. The law is legitimating the commercialization of health care, ignoring the fact that over 38% of the population lives below the poverty line.[200]

According to UDHS (2001), over 50% of health facilities are in urban areas, yet 80% of the population lives in rural areas. Consequently, most of the people utilize the services of Traditional Health Practitioners (THP), including Traditional Birth Attendants (TBAs). THETA has brought TBAs on board as key stakeholders in the PMCT programme. TBAs offer counseling services to HIV/AIDS and make referrals for PMCT, VCT and other related services. Traditional and Modern Health Practitioners Together against AIDS and other Related Diseases (THETA) has built referral networks between TBAs and the bio-medical health system. TBAs are trained to provide quality health care services as the health care

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[195] Cap. 272, Laws of Uganda.
[196] Sec. 3 (a) – (d).
[197] Sec. 3 (e).
[198] Sec. 3 (f).
[199] Sec. 42.
[200] PEAP, note 11. However, poverty is said to have reduced to 31%. See, UBOS, Uganda Household Survey 2005/2006, cited in Patience Atuhaire, 'Poverty levels reduce' Daily Monitor, December 14, 2006 at p.1.

delivery system is improved.[201] It is however disappointing to note that in spite of the role played by traditional health care in the management of HIV/AIDS and other diseases, there is no law regulating the activities and general functioning of THP. There is consequently a need to expedite enactment of the law that will regulate traditional medical practice and eliminate the quacks.

The Uganda Aids Commission Act[202] establishes the Uganda Aids Commission (UAC) whose mandate includes the formulation of policy and establishment of programme priorities for the control of the AIDS epidemic and management of its consequences throughout the country.[203] Other functions include identification of obstacles to the implementation of AIDS control strategies and the dissemination of HIV/AIDS-related information and its consequences.[204] UAC is also charged with supervising all activities relating to the control of the AIDS epidemic, including *inter alia*, health care and counseling of AIDS patients, the handling of socioeconomic, cultural and legal issues related to the epidemic and to find a cure for the disease.[205]

The Right to Private and Family Life

The right to private and family life is distinguishable from the right to found a family, although for some purposes the latter right may be considered to be part of the former. The right to private and family life implicates liberty interests. The Political Covenant provides that "*no one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation.*"[206] The European Convention specifies

[201] Interview with Grace Nanyonga, Library, Information and Research Officer, THETA.
[202] Cap. 208, Laws of Uganda.
[203] Sec. 5 (a).
[204] Sec. 5 (c) and (e).
[205] *Ibid.*
[206] Political Covenant, *supra* note 27, art. 17(1), 999 U.N.T.S. at 177. This Article builds on article 12 of the Universal Dec .

conditions under which private and family life may be compromised or sacrificed to higher interests of the state.[207] Article 8 provides that:

> 1. Everyone has the right to respect for his private and family life, his home and his correspondence.
>
> 2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.[208]

Observations have been made inspired by both domestic constitutional laws and international human rights adjudication regarding reproductive self-determination. For example, the European Commission in the *Paton* case[209] upheld a British decision preventing a woman from being coerced to continue an unwanted pregnancy through her husband's veto of her abortion. The Commission gave priority to respect for a wife's private life in her decision on child bearing over her husband's right to respect for his family life in the birth of his child, and found that it could not interpret the husband's right to embrace even a right to be consulted on his wife's decision.[210] The state's interest in an unborn life is not greater than that of the biological father's, so that preclusion of his right necessarily precludes the state's right to prevail.

The Patents Act[211] grants a lot of protection to patent-holders because it excludes parallel importation and restricts the application for compulsory licenses to very limited grounds.1[212] However, the Act contains a number of flexibilities, which when employed could go a long way in enhancing the availability of ARVs. Under the statute, the Ministry of Health may, for

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[207] A.M. Connelly, *Problems of Interpretation of Article 8 of the European Convention on Human Rights*, 35 INT'L & COMP.L.Q. 567 (1986).

[208] European Convention, *supra* note 29, art. 8, 213 U.N.T.S. at 230.

[209] *Paton v. United Kingdom*, 3 Eur.H.R.Rep. 408 (1980).

[210] *Ibid.* at 417.

[211] Cap. 216 Laws of Uganda.

[212] On the rights of the patent holder, see Sec. 25 which grants a patent holder exclusive permission to make, use, exercise and vend the invention. See also Sec. 26 on infringement. On compulsory licensing, see Sec. 30 of the Act.

the reason of 'vital public interest',[213] including matters pertaining to public health, request patent-holders to surrender their patent rights in Uganda.[214] It should be noted that unlike the TRIPS agreement, the Patents Act limits the term of a patent to 15 years.[215] To conclude, the legal framework in Uganda is a real 'mixed grill.' Some of the provisions of the law are inadequate. Others sound noble from a human rights perspective, but their implementation is inhibited by constraints that adversely affect the capacity of the state.

The Negative Consequences of Globalization

One of the hallmarks of globalization from above is the erosion of the state's capacity to realize economic, social and cultural rights such as the right of access to ART. The state is compelled to take measures that adversely impact on the right of WLA to access ART. Because of the dictates of globalization, the state has largely embraced free market economic policies. The state has given a disproportionate weight of priority to economic growth to the detriment of social services such as health care. The following analysis examines the salient aspects of globalization that have a deleterious impact on the state's responsibility to protect the right under inquiry.

Funding for the Health Sector: a Question of Prioritization?

All the key informants disclosed that the most serious bottleneck to the provision of ART is a lack of sufficient funding. Funding is critical for the provision of both physical and human infrastructure. Although the Abuja Declaration recommends that states should allocate at least 15% of their national budgets to health,[216] Uganda spends only 8% on health and certainly this has serious implications on the provision of ART.[217] But how can this funding problem be explained? The institutions of globalization, especially the

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[213] Sec. 29 (3).
[214] See, sec. 29 (1) and (3). See also, sec. 35.
[215] Sec. 31.
[216] Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases (2001) OAU/SPS/ABU/326.
[217] *Ibid*.

World Bank and the IMF argue that increasing public health spending undermines macroeconomic stability.[218]

It is the macroeconomic model designed by these institutions that sets rigid budget ceilings for each ministry including the Ministry of Health.[219] It is also important to note that the IMF seems to prefer prevention strategies to treatment measures, because the costs involved are likely to have inflationary tendencies.[220] Another possible explanation of the funding problem is the debt crisis. Uganda's foreign debt is estimated at approximately US$ 4 billon and the country's net present value of debt to exports stands at 305%.[221]There is no doubt whatsoever that the debt burden undermines the state's capacity to provide social services to its people.

The external debt is not sustainable. According to the PEAP, external loans currently account for 40% of donor funds in any given year.[222] As a Highly Indebted Poor Country (HIPC), Uganda has benefited from debt relief.[223] Money saved from debt relief is supposed to be invested in poverty alleviation programmes, which include the minimum health care package as outlined in the HSSP.[224] However, debt relief is simply that a relief, which assumes that HIPC countries continue to borrow to increase spending on poverty reduction leading to future debt build-up. For example, in 2000, debt relief of US$ 1 billion was pledged, but since then Uganda has borrowed US 1.5 billion.2[225] As the PEAP admits, Excessive aid dependency inevitably impinges on the sovereignty of the aid recipient and constrains its economic and budgetary choices, which is not consistent with the development of a healthy and equal relationship

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[218] Interview with Ministy of Finance official who requested anonymity.
[219] Interview with Dr. Nelson Musoba, Ministry of Health, Kampala.
[220] *Ibid*.
[221] PEAP, note 11 at xvii.
[222] *Ibid.*
[223]See,World Bank,Uganda CountryBrief(2005), available at http://web.worldbank.org/SITE/EXTERNAL/COUNTRIES/AFRICAEXT/UGANDAEXTN/0, accessed July 3, 2006.
[224] *Ibid.*
[225] PEAP, note 11 at 41.

between aid recipients and the donors, based on mutual respect. Reducing dependency on aid is crucial for the development of democracy and the accountability of government.[226]

Debt relief and donor dependency generally are not a panacea for the human rights violations resulting from the debt burden. In my considered opinion, the only sustainable solution to the debt burden is debt cancellation with a major condition that significant portions from the savings from debt cancellation go toward social welfare programmes like health care and education. Otherwise, debt service repayments will continue to undermine the state's capacity to meet its minimum core obligations such as enhancing access of WLA to ART.[227]

The funding problem can also be explained by a lack of democratic accountability. Health care issues such as access to ART are not prioritized. One key informant told this researcher that, Let me be candid with you. Money for ART and other related health issues would be readily available if these were taken as a priority. If all the money that goes into ostentatious expenditure was channeled to ART, all urban and rural public health centres would have ART and the attendant requirements like equipment and personnel. This article provides policy space to take measures for the protection of the right under investigation. It should also be noted that though not explicitly couched in human rights terms, the preamble to the WTO agreement provides that the objectives of the trading system include the improvement of living standards for all people. The Doha Declaration on the TRIPS agreement and Public Health stresses that the right to health plays an essential role in the interpretation of the agreement. The Declaration states as follows:

We agree that the TRIPS agreement does not and should not prevent members from taking measures to protect public health. Accordingly, while reiterating our commitment

[226] PEAP, note 11 at 41.
[227] *Ibid.*

to the TRIPS Agreement, we affirm that the Agreement can and should be interpreted and implemented to protect public health and, in particular, to promote access to medicines for all.[228] It should be noted that the TRIPS Agreement contains a number of flexibilities that could be utilized to protect the right to health especially access to ART. The agreement allows parallel importation, that is, the importation without the patent owner's approval, of products marketed by the patent owner at relatively cheaper prices in another country.[229] The agreement also permits compulsory licensing, that is, the production of drugs without the patent owner's approval.[230] Two conditions must be met. The state or company authorized on its behalf must have failed to procure a voluntary license from the patent owner. Secondly, compensation should be paid to the patent owner.

It is important to note that the so-called flexibilities may indeed be of no serious value for least developed countries like Uganda. This is because the countries have limited research and development capacity. Given that most of the ART is donor funded, only patented drugs may be availed to the recipient country. Countries like India do not provide product patents on pharmaceuticals and food products. Consequently, Uganda may acquire generic drugs from such countries. But this requires sufficient funds, which the state may not have. Compulsory licensing may also not be possible for poor countries like Uganda, given that locally-based companies may not have the capacity to compete with the global pharmaceutical companies who reap from economies of scale and sell at relatively low prices.[231]

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[228] Para. 4 of the Declaration. The Declaration is cited in F.M. Abbott' (2002).
[229] *Ibid.*
[230] *Ibid.*
[231] *Ibid.*

The Right to Reproductive Health and Health Care

By article 12(1) of the Economic Covenant, states parties "recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." Article 12(2) provides that the steps to achieve the full realization of this right shall include those necessary for:

a) The provision for the reduction of the still-birth rate and of infant mortality and for the healthy development of the child...

d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Article 12 addresses reproductive health services indirectly, in that multiple pregnancies and short birth intervals endanger infant survival and health.

The breadth of the concept of "health" is apparent in the Preamble to the Constitution of the World Health Organization, which describes health as "*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.*"[232]

In this sense, idealistic or ambitious though it may appear, the right to seek the highest attainable standard of health is inherent in every human being. Because mental and social well-being are components of health, unwanted pregnancy that endangers mental or social well-being is as much a threat to women's health as is pregnancy that endangers survival, longevity or physical health.

Women may claim a negative right of recourse to contraception and sterilization without legal obstruction, and perhaps a positive right to be afforded access to related counseling and services. Similarly, women may claim a right to arrange abortion, particularly when their personal history raises the medical risks of pregnancy far above those faced by other women in their communities. Abortion is the practice of medicine,

[232] Preamble to the Constitution of the World Health Organization, 2 Official Records of the World Health Organization 100 (July 1946).

and women may claim access to physicians capable of undertaking the procedure safely. That is, the right to an abortion to preserve health may be claimed as a positive right where any negative right would be capable of exercise through unqualified practitioners whose procedures are themselves a risk to women's health.

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

CHAPTER SIX

FINDINGS, CONCLUSIONS, RECOMMENDATIONS

This chapter dealt with the findings, conclusions and recommendations of the study.

Conclusions

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

Reproductive health as a human right is protected by both international and domestic law. It is important that these provisions are enforced and remedies obtained whenever the state is found to be in violation. This is what Constitutional Petition No. 16 seeks to do. The right to health has been the subject of judicial enforcement in cases across the globe. Even before judgment is handed down, Constitutional Petition No. 16 has already highlighted the systemic violation of the reproductive health rights of women, arising from both unethical neglect and the lack of essential medicines and facilities.

Over the past ten years, treaty-monitoring bodies' interpretations and jurisprudence regarding women's human rights have led to a marked expansion in recognition of the right to health, particularly as it relates to women's reproductive health. With this foundation, advocates have been given a platform to further reinforce the right to health and protections of health by making linkages to other human rights. As such, they have pressured governments to comply with their international human rights obligations related to health through litigation.

As the first phase of advocacy has led to increased recognition of the right to health, advocates must continue to devise creative strategies and pursue them in multiple fora to further promote the right to health as an independent, justiciable right, while still

recognizing the intricate interdependence between all human rights. In the process, advocates should also ensure that women's experiences are addressed and redressed within the human rights framework. In the end, it is the synergy between human rights that makes the dynamic advancement of the human right to health possible.

The formulation of domestic laws and ratification of some international laws in Uganda, there has been improvement in women's health like the prioritization of maternal health in the Health Sector Strategic Plan, the development of a Road-map for Reduction of Maternal and New-born Mortality and Morbidity and that the number of children who die before their first birthday has reduced from 88 to 75 per 1000 live births during the same period. However, despite a slight decline, maternal mortality rates remain very high (505 in 2001 to 435 per 100,000 in 2006), with clandestine abortions being a major cause of this. There are very high number of teenage pregnancies, women's limited access to quality reproductive and sexual health services, especially in rural areas, and that the existing sex education programmes are not sufficient, and may not give enough attention to the prevention of early pregnancy and the control of STIs.

Recommendations

The Legal Framework

There is an urgent need to explicitly recognize the right to reproductive health care in the Constitution, which could clear any misgivings about the justiciability of the right. However, recognizing the right in the Constitution is not sufficient. Legal and policy instruments must underpin the Constitution. To this end, there is an urgent need for a health legislation that makes it unequivocal that the state is under an obligation to provide adequate, affordable and accessible health care, including ARV's to its people with special attention to the poor and vulnerable. The legislation should contain measurable benchmarks and targets against which state performance can be measured. The legislation should also include provisions on periodic review, monitoring and evaluation of performance of the relevant reproductive health sectors.

Education and Enlightenment

The research recommends that there is need of improvement in girl child education. This could go a long way in making the girl- child less susceptible in reproductive rights violations. Mass enlightenment is also vital; mass media and other fora of public enlightenment need to be further explored to expose women to better reproductive rights.

Further there is need for increased funding in maternal education.

Judicial Protection

Courts can play a crucial role in improving reproductive health rights. Judicial officers especially judges of the higher courts can be creative in their interpretation of relevant constitutional provisions to compel the state to meet its obligations under international human rights law. Where the Constitution is silent, judges can invoke the provisions of international human rights instruments. Article 45 gives them the mandate to look at other rights not specifically provided for in the Constitution. Judges can also rely on national case law within the Commonwealth that has tackled the right in question.

In a bid to improve women's reproductive rights in Uganda, the following recommendations suggest some policy intervention and change in ways of practice at national and international level.

Uganda should clarify its laws concerning abortion and amend its Penal Code to reflect the circumstances permitting legal abortion set forth in its Reproductive Health Guidelines. Uganda should also remove its reservations to Articles 14(1)(a) and 14(2)(c) of the Maputo Protocol.

Uganda should comply with the CEDAW Committee"s recommendation in 2010 to strengthen efforts to reduce maternal mortality.

The government should take steps to increase knowledge and awareness about family planning through awareness-raising and sexuality education, with an emphasis on adolescent education.

Uganda should comply with the CEDAW Committee"s recommendation in 2010 to eliminate harmful traditional practices, such as polygamy, early marriage and Female Genital Mutilation , including review, amendment, and passage of the Marriage and Divorce Bill .

The study recommends that the government should ensure the effective implementation of the 2010 Prohibition of Female Genital Mutilation Act, as well as prosecution and adequate punishment of perpetrators of this practice. The Committee recommends that the State party continue and increase its awareness-raising and education efforts, targeted at both men and women, with the support of civil society organizations and religious authorities, in order to completely eliminate FGM and its underlying cultural justifications. Such efforts should include the design and implementation of effective education campaigns to combat traditional and family pressures in favour of this practice, particularly among those who are illiterate, especially parents.

Furthermore, this study recommends that the government avail itself of technical assistance in the development and implementation of a comprehensive programme aimed at the implementation of the women's reproductive Convention as a whole. The study suggests that the government strengthen further its cooperation with specialized agencies and programmes of the United Nations system.

The study recommends that the low cut suit also known as the Non- pneumatic Anti – Shock Garment be introduced in Uganda following tests in Nigeria and Egypt. It acts as an anti-shock garment which applies pressure to a woman's lower body to help control post partum bleeding. The garment can keep a mother alive until she is treated for

postpartum hemorrhage. If a garment is worn properly it can be used about 40 times. This garment has the ability to save thousands of lives of women who suffer from bleeding after birth by extending the time the woman can wait for medical interventions by up to 6(six) to 48 (forty eight) hours. Made from neoprene (the same material used to make delivery suits) the suit is wrapped around the mothers legs , pelvis and abdomen then tightened with Velcro straps. The tightening from the legs upwards applies pressure on the lower body, forcing blood up to the essential core organs, heart , lungs and brain. This could help reduce maternal deaths caused by bleeding after giving birth.

Education on human rights violation on the issues concerning reproductive health should be emphasized There should be greater availability of youth-friendly information and services, through schools, pharmacies and outreach activities in the health sector as well as through NGOs and community-based organizations for social services. Youth advisory committees and other youth-to-adult mechanisms should be established for advocacy, policy dialogue and programme development and management. Advocacy will include continued education, vocational and economic opportunities, and empowerment programmes, especially for girls especially on reproductive health rights..

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APPENDIX I

INFORMED CONSENT

I am giving my consent to be part of the research study of M/s Twikirize Parton that will focus on **"Women Reproductive Rights: An Examination of the Emerging Legal Practices in Uganda"**

I have been assured of privacy, anonymity and confidentiality and that I will be given the option to refuse participation and have the right to withdraw my participation anytime.

I have been informed that the research is voluntary and that the results will be given to me, if I ask for it.

Initials:_____

Date_____

APPENDIX II

CLEARANCE FROM ETHICS COMMITTEE

Date_____

Candidate's Data

Name_____

Reg.# _____

Course _____

Title of Study _____

_____

Ethical Review Checklist

The study reviewed considered the following:

___ Physical Safety of Human Subjects
___ Psychological Safety
___ Emotional Security
___ Privacy
___ Written Request for Author of Standardized Instrument
___ Coding of Questionnaires/Anonymity/Confidentiality
___ Permission to Conduct the Study
___ Informed Consent
___ Citations/Authors Recognized

Results of Ethical Review

___ Approved
___ Conditional (to provide the Ethics Committee with corrections)
___ Disapproved/ Resubmit Proposal

Ethics Committee (Name and Signature)

Chairperson _____

Members _____

APPENDIX 111
INTERVIEW GUIDE

1. Have you ever heard of reproductive rights?

   Yes ☐

   No ☐

2. What do you think are the causes of reproductive rights violations?

   (*Number/tick in order of preferences. Start with the most probable.*)

   Customs

   Illiteracy

   Poor law

   Enforcement

   Inadequate law

   All of the above.

5. Are you aware of the relevant laws on reproductive right?

   Yes ☐

   No ☐

4. How do you assess the level of compliance with women reproductive rights in Uganda?

   Good ☐

   Bad ☐

   Fair ☐

   Excellent ☐

   All of the above ☐

6. what steps should be taken to enhance awareness?

Education ☐

Funding ☐

Media ☐

Legislation ☐

Other (specify) ☐

7. What is your assessment of the redress mechanism?

Good ☐

Poor ☐

Fair ☐

Excellent ☐

9. In which area do you think there is need for further legislative intervention?

Abortion ☐

Right of divorce

Reproductive education ☐

All ☐

11. Do you think customs have positive role to play in women reproductive rights

Yes ☐

No ☐

12. Do you think religion has a positive role to play in women reproductive rights.

Yes ☐

No ☐

13. Do you think government has a positive role to play in women reproductive rights

Yes ☐

No ☐