

MATERNAL HEALTH RIGHTS, POLITICS AND THE LAW

Professorial Inaugural Lecture

Ben Kiromba Twinomugisha



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Dedication

To my beloved wife, lover and friend, Anne; our children, Faith, Brenda, Rhona and Jenkins; and all women and men in the struggle to realize women's human rights generally and maternal health rights in particular.

Profile

Prof. Ben KirombaTwinomugisha is a full Professor of Law and former Dean, School of Law, Makerere University. He is the first Doctor of Laws (LL.D.) degree graduate of Makerere University. He has previously worked in Ministry of Lands as a Lands Officer, National College of Business Studies as a lecturer and practised law with Sam Kutesa & Co. Advocates and Twinomugisha Shokoro & Co. Advocates. He has more than 30 years of experience in academia and legal practice in areas including commercial law and public law, as they pertain to issues of international and domestic law. He has taught and examined in a number of universities in the region. He has also published in the areas of environmental law, gender, health and human rights. He has recently published a multidisciplinary book, *Fundamentals of Health Law in Uganda*. Pretoria: Pretoria University Law Press (2015). He is also a Rotarian, Rotary Club of Ntinda.

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I wish to thank my wife, lover and friend, Anne to whom I have been married for 30 years and our children, Faith, Brenda, Rhona and Jenkins for accommodating my views on governance of the country and women's sexual and reproductive health rights. As I always say, that is how it should be: a united family with diverse approaches to phenomena. I also thank some of my Health and the Law students who always challenge me about these views. During the lectures, we accommodate each other's viewpoints: all perspectives are accepted provided they are supported by relevant literature and authorities. I am also grateful to all those authors whose works I have cited and used in this professorial inaugural lecture.

I wish also to thank my colleagues at the School of Law, with whom I have worked as an academic and administrator. I will forever be indebted to you for your support. Special thanks go to my former undergraduate lecturers, Frederick Jjuuko and Deogratius Mbirizi, who patiently taught me the multidisciplinary approach to law especially through the Marxist-Leninist dialectical approach. I vividly remember Mbirizi's statement in first year Law of Contract class: 'Law cannot operate in a vacuum; it is part of the superstructure and is determined and influenced by the economic base'.

I also have to specifically mention Joseph Oloka-Onyango, my doctoral supervisor and mentor, Sylvia Tamale, John J. Barya, Busingye Kabumba, Benson Tusasiirwe, Tumwine-Mukubwa, and Ronald Mayambala Kakungulu, whose notions about law and politics have over the years inspired me. I am also indebted to Zahara Nampewo, Gracia Mugalula and Philda Maiga with whom we co-teach Health and the Law. I know that with God's amazing grace, you will take the subject to greater heights. I also thank David Bakibinga – a man who would always counsel me, 'Ben, when are you applying for promotion? Publish!'. David Bakibinga and Francis Birikadde have ably commented on and edited this lecture. I am very grateful to you for offering services in this regard.

Finally, permit me to thank my former students in the NGO world who have taken the discipline of health and human rights to the real world. Here I would like to specifically mention Moses Mulumba and David Kabanda of Centre for Health, Human Rights and Development (CEHURD), who are engaged in daily struggles for protection of health rights in the country. I am really proud of you.

To my present and former employers, thank you for your support. Thank you for accommodating my character. I may not be an easy subordinate but as Jesus Christ, my master, commands me, I love you all. To the 'Big Five' – Alex, Willy, Sande, Ambrose, Ben, our spouses, Christine, Jacqueline, Sarah, Juliet, Anne and children – let us toast to this and other achievements. I love you.

Abstract

Uganda is a party to international and regional human rights instruments that recognize maternal health rights (MHRs). It also has a Constitution and policy frameworks, which contain provisions with a bearing on MHRs. In spite of the recognition of MHRs in legal and policy frameworks, realization of these rights remains elusive as evidenced by the alarming rates of maternal mortality and morbidity. Consequently, this lecture seeks to answer the following question: why does realization of MHRs remain elusive in Uganda? I argue that realization of MHRs remains elusive because the Ugandan state, which has the primary responsibility to protect MHRs, relies on neo-liberal policies and criminal laws, which exalt private and class interests to the detriment of maternal health issues. I also argue that it is not a mere lack of resources that explains non-realization of MHRs in Uganda, but absence of political will to tackle the structural causes of maternal mortality and morbidity. The lecture advances juridical, administrative and other measures to tackle neo-liberal policies, criminal laws, and inequitable gender relations, which inhibit women from realizing their MHRs.

Abbreviations

ACHPR	African Charter on Human and Peoples' Rights
ACRWC	African Charter on the Rights and Welfare of the Child
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CEHURD	Centre for Health, Human Rights and Development
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
CSO	Civil Society Organizations
EmOC	Emergency Obstetric Care
HRAPF	Human Rights Awareness and Promotion Forum
GATS	General Agreement on Trade and Services
ICESCR	International Covenant on Economic, Social and Cultural Rights
IMF	International Monetary Fund
IPRs	Intellectual Property Rights
LDC	Law Development Centre
LLD	Doctor of Laws
LLM	Master of Laws
MHRs	Maternal Health Rights
MMR	Maternal Mortality Ratio
MOFPED	Ministry of Finance Planning and Economic Development
NCBS	National College of Business Studies
NGO	Non-Governmental Organization
PIL	Public Interest Litigation
SDG	Sustainable Development Goal
TRIPS	Trade Related Aspects of Intellectual Property Rights

- UBOS** Uganda Bureau of Statistics
- UDHR** Universal Declaration of Human Rights
- UCC** Uganda College of Commerce
- WHO** World Health Organization
- WTO** World Trade Organization

Legislation

Constitution of the Republic of Uganda, 1995

Medical and Dental Practitioners Act, cap. 272

Nurses and Midwives Act, cap. 274.

Private Hospitals (Regulation) Act, cap. 151 (Tanzania)

Human Rights Instruments

Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases

Addis Ababa Declaration on Population and Development in Africa Beyond 2014

African Charter on Human and Peoples' Rights

Beijing Platform of Action

African Charter on the Rights and Welfare of the Child

Cairo Programme of Action

Constitution of the World Health Organization

Continental Policy Framework on Sexual and Reproductive Health and Rights

Convention on the Elimination of all Forms of Discrimination against Women

Convention on the Rights of the Child

Convention on the Rights of Persons with Disabilities

General Comment No. 14, 'The Right to the Highest Attainable Standard of Physical and Mental Health'

General Comment No. 22, 'The Right to Sexual and Reproductive Health'.

International Covenant on Economic, Social and Cultural Rights

Plan of Action on Sexual and Reproductive Health and Rights (Maputo Plan of Action)

Universal Declaration of Human Rights

Vienna Declaration and Programme of Action

Introduction

Ladies and gentlemen, in your distinguished capacities, permit me to briefly take you through my law teaching career, which has culminated into this professorial inaugural lecture. Thirty years ago, in October 1986, after completing my Diploma in Legal Practice at the Law Development Centre (LDC), I started teaching law at Makerere University as a teaching assistant, and at Uganda College of Commerce (UCC), later named National College of Business Studies (NCBS), Nakawa, as a lecturer. My major focus was on commercial laws. Over the years, I have taught Bankruptcy Law, Law of Sale of Goods, Company Law, Mercantile Law, General Principles of Law, and Law of Contract. When I embarked on a Master of Laws (LL.M), I switched to a completely new area: Environmental Law and Policy. I never thought that in my law teaching career I could venture into the disciplines of health, gender and human rights. However, around February/March 1997, while walking around my village in Kitanga, Mparo, Kabale District, I saw my aunt in the garden weeding sorghum. I went to greet her. She held me firmly and said: ‘My son, it is good you have come. I have malaria. I have taken herbs and some tablets (hedex), which I bought from the shop at the trading centre, but I am not okay’. I asked her: ‘Why didn’t you go to the clinic for proper check up and treatment?’ Touching her hip, she politely replied: ‘My son, “*omworo tarwara*”, that is, “the poor do not fall sick”. I gave her money and she got anti-malaria tablets from the clinic.

For the next couple of days, I kept pondering over the conversation I had with my aunt. Two weeks later, I boarded a bus to my village to find out more about the challenges of accessing health care. During my interaction with some men and women over *tonto* and *muramba*— banana and sorghum local brew respectively – I found that they face many challenges, including poverty, in their quest to access health care. This motivated me to pursue a Doctor of Laws (LL.D) degree, which sought to interrogate the challenges of rural poor women in accessing maternal health care in a rural sub county – to be specific – Kashambya in Kabale District. Encouraged by the findings of the doctoral study, I together with Dr.

Esther Kisakye, now a Justice of the Supreme Court of Uganda, started a Health and the Law course at the School of Law, Makerere University. This course motivated me to write a book, *Fundamentals of Health Law in Uganda* (Pretoria University Law Press, 2015), which is now a major sourcebook for students and practitioners of Health Law and Policy.

I have, over the years, researched and published on protection of rural women's maternal health rights (MHRs); enforcement of criminal abortion laws; the tension between customary law and women's human rights; the role of the gender perspective in interrogating the right to health; globalization and the protection of women's human rights; juridical strategies for protection of the right of access to emergency obstetric care; and the right of access to medicines in the context of the intellectual property regime. I have also supervised and examined undergraduate and graduate students in universities here and abroad in the area of health rights. This lecture, which interrogates structural or root causes of non-realization of maternal health rights (MHRs), is thus a continuation of this law teaching journey: from a focus on commercial and environmental laws to the multidisciplinary discourse of health, gender, and human rights.

In the course of my law teaching journey, I have discovered that one of the major achievements in the development of human rights has been the recognition that women's rights are human rights and that issues of gender equality and non-discrimination against women in all fields, including health care, should form an integral part of international relations. Thus, it is now recognized, at least at the normative level, that women's human rights, such as MHRs, are an inalienable, integral and an indivisible part of universal human rights.¹ MHRs, which are essential components of women's right to health, are recognized at the international, regional and national levels. Uganda is a party to a number of international and regional human rights instruments that provide for the right to health, including MHRs.² Uganda also subscribes to various consensus documents, which emphasize the protection of these rights.³ The Constitution

1 Vienna Declaration and Programme of Action, para. 18.

2 See for example, article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR); articles 12 and 14 of the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW); article 24 of the Convention on the Rights of the Child (CRC); article 25 of the Convention on the Rights of Persons with Disabilities (CRPD); article 16 of the African Charter on Human and Peoples' Rights (ACHPR); article 14 of the African Charter on the Rights and Welfare of the Child (ACRWC); and article 14 of the Women's Protocol to the ACHPR.

3 See for example, Cairo Programme of Action (United Nations, Report of the International Conference on Population and Development, Cairo, 5-13 September 1994. New York: United Nations, 1995); Beijing Platform of Action (United Nations, Report of the Fourth World Conference on Women, Beijing, 4-15 September 1995. New York: United Nations, 1996); African Union, Addis Ababa Declaration on Population and Development in Africa Beyond 2014. ECA/ICPD/MIN/2013/4, 4 October 2013; African Union, The Continental Policy Framework

of the Republic of Uganda (hereafter: ‘the Constitution’) also has a specific provision on women’s human rights⁴ and other provisions, which have a bearing on MHRs.⁵ There are also health-related policy frameworks aimed at ensuring that women enjoy their sexual and reproductive health rights, including MHRs (Ministry of Health, 2010a; 2010b; 2012; 2015a).

In spite of the above progressive legal and policy frameworks which underline protection of the right to health generally and MHRs in particular, realization of these rights remains elusive as evidenced by the worrying maternal health related statistics. For example, although Uganda has an estimated population of 35.8 million people, the fertility rate hovers between 6 and 7 per cent among women aged 15–49 years (UBOS, 2012; UBOS, 2016). The contraceptive prevalence rate (CPR) is at 30 per cent while the unmet need for family planning is at 34 per cent (ibid). Only 58 per cent of births are attended to by skilled health personnel (ibid). 32 per cent of women are also anemic (UBOS, 2016), which points to challenges of iron deficiency – a key indicator of maternal malnutrition. 42 per cent of women deliver from home (ibid). Albeit access to quality emergency obstetric care (EmOC) is fundamental to reducing maternal deaths and injuries, the proportion of facilities providing appropriate EmOC is still low at only 26 per cent (Ministry of Health, 2010a). The national met need for emergency obstetric care (EmOC) is at only 40 per cent, yet this type of care is very critical for 15 percent of women who develop complications during pregnancy (ibid). In fact, only 11.7 per cent of women deliver in fully functional comprehensive EmOC facilities (ibid). There are also 300, 000 abortions in Uganda every year (Prada, 2016: 9) and unsafe abortions contribute up to 26 per cent of maternal deaths (Ministry of Health, 2015a). Draconian criminal abortion laws,⁶ cultural and religious restrictions, force women and girls to resort to unsafe methods in order to terminate unwanted pregnancies. And unsafe abortion leads to a violation

on Sexual and Reproductive Health and Rights; African Union, Plan of Action on Sexual and Reproductive Health and Rights (Maputo Plan of Action), Sp/MIN/CAMH/5(1).

4 See article 33 of the Constitution of the Republic of Uganda, 1995 (as amended).

5 See for example, National Objectives and Directive Principles of State Policy, Objective XX (medical services); and XXIV (food security and nutrition); articles 21 (equality and non-discrimination); article 22 (right to life); article 23 (personal liberty); article 24 (respect for human dignity and protection from cruel, inhuman or degrading treatment); article 29 (freedom of conscience); article 30 (education); article 31 (family rights); article 32 (affirmative action); article 34 (children’s’ rights); article 35 (disability rights); article 28 (participation rights); article 40 (economic rights); and article 41 (access to information).

6 Abortion is criminalized in Uganda under sections 141 (attempts to procure an abortion); 143 (procuring miscarriage); 143 (supplying drugs, etc. to procure abortion); and 212 (killing unborn child). Although article 22(2) of the Constitution provides that, ‘[n]o person has the right to terminate the life of an unborn child except as may be authorized by law’, Parliament, which has the primary authority to enact legislation in Uganda (article 79(1), has not passed any law allowing termination of pregnancy. For a discussion of these provisions, see Twinomugisha (2015: 50-53); Human Rights Awareness and Promotion Forum (HRAPF) (2016); Ngwena (2014); CEHURD (2016).

of a whole range of maternal health related rights such as life; bodily integrity and self determination; privacy; health; equality and non-discrimination; human dignity; and liberty and security of the person (HRAPF, 2016).

There is no doubt that health workers play critical roles in any health system (Ministry of Health, 2015b) and 'sufficient, competent, equitably distributed, motivated and facilitated health workers have to be available at all levels of the health system in order to achieve a good standard of health by all people in Uganda' (ibid). However, in Uganda, there is a substantial shortage of skilled health care providers such as doctors, nurses and midwives to meet maternal health needs. In fact, the health worker population ratio is 1:1298 compared to the World Health Organization (WHO) recommended ratio of 1:439 (MOFPEd, 2010). In 2010, the doctor - patient ratio stood at 1:24,725 and the nurse -patient ratio at 1:11,000.⁷ Due to poor working conditions, especially low salaries, doctors are moving to other countries for better pay.⁸ And to government, it is business as usual: instead of developing strategies to motivate and retain health workers, it has encouraged the export of this scarce resource to countries such as Trinidad and Tobago.⁹ Yet, one of the key factors in reducing maternal mortality and morbidity is the availability of and access to skilled health personnel.

It is not surprising therefore, that like in most countries of Sub-Saharan Africa,¹⁰ the maternal mortality Ratio (MMR)¹¹ in Uganda is still high at an estimated 336 deaths per 100,000 births, roughly translating into an estimated 16 women dying per day giving birth (UBOS, 2016). Although data indicates a decline in MMR from 438 in 2009 (UBOS, 2012), this is still unacceptable since no woman should die due to avoidable maternal causes. Maternal morbidity rates are also high.¹² In addition to every woman who dies, an estimated six women survive with chronic and debilitating ill health and injuries such as fistulae –the leaking of urine or

7 MOFPEd, 'Health Workers Shortage in Uganda: Where should the government focus its efforts?', [http://www.finance.go.ug/dmdocuments/6-13Health Workers Shortage in UgandaMay2013.pdf](http://www.finance.go.ug/dmdocuments/6-13Health%20Workers%20Shortage%20in%20UgandaMay2013.pdf) (accessed 8 December 2016).

8 Global Development, 'Uganda crippled by medical brain drain', <http://www.theguardian.com/global-development/2015/feb/10/Uganda-crippled-medical-brain-drain-doctors> (accessed 8 December 2015).

9 See for example, AFP, 'Uganda government insists on sending 240 health workers to Caribbean' *Daily Monitor*, 17 March 2015.

10 In 2013, Maternal Mortality Ratio (MMR) was at 400 in Kenya; 320 in Rwanda; 740 in Burundi; and 360 in Uganda. In 2015, MMR was estimated at 510 in Kenya; 398 in Tanzania; 290 in Rwanda; and 343 in Uganda. See, WHO (2013: 2-4); The World Bank, Maternal Mortality Rate (Modeled Estimate, per 100,000 live births), <http://worldbank.org/inicators/Slt.STA.MMRT> (accessed 2 November 2016).

11 MMR is the ratio of the number of maternal deaths during a given period per 100,000 live births during the same period.

12 Maternal morbidity has been defined by the maternal Morbidity Working Group (MMWG) as 'any health condition attributed to and/or aggravated by pregnancy and childbirth that has a negative impact on the woman's wellbeing', <http://who.int/bulletin/volumes91/10/13-117564/en/> (accessed 2 November 2016).

feaces from the vagina.¹³ Given this situation, it is very doubtful whether Uganda will meet Sustainable Development Goal (SDG) 3, which sets a target of reducing maternal mortality rate to less than 70 per 100,000 live births by 2030.¹⁴

Against the above backdrop, today's lecture seeks to answer the following questions: Why is realization of MHRs elusive in Uganda? Why do women continue to die or suffer injury due to avoidable maternal causes? I argue that realization of MHRs remains elusive because the Ugandan state, which has the primary responsibility to protect MHRs, relies on neo-liberal policies and criminal laws, which exalt private and class interests to the detriment of maternal health issues. Neo-liberalism, in the Ugandan context, refers to a greater reliance on the private sector, with the state playing a more subservient role in the provision of health services. I also argue that it is not a mere lack of resources that explains non-realization of MHRs in Uganda but absence of political will to tackle the structural causes of maternal mortality and morbidity. The lecture is divided into five sections. The first section is this introduction. The second section provides the theoretical perspective for the subject under discussion. The third section briefly delimits the nature, scope and content of MHRs. In the fourth section, I examine the causes of maternal mortality and morbidity in Uganda with the view of determining why the realization of MHRs remains elusive. The fifth section suggests modalities for advancing the realization of MHRs.

13 Ibid.

14 UNGA, Transforming Our World; The 2030 Agenda for Sustainable Development, Resolution 70/1, Adopted on 25 September 2015.

2

Theoretical Perspectives

Ladies and gentlemen, permit me to take you back to the main question that this lecture seeks to address: Why does realization of MHRs remain elusive in Uganda? This question, in my humble view, transcends a purely juridical analysis: it is multifaceted, multifocal, multifarious and multi-disciplinary and thus requires a holistic approach. Indeed, various factors— internal and external— explain the non-realization of MHRs in Uganda. The question therefore is: from what theoretical perspective can the issues canvassed in this lecture best be handled? My view is that no single perspective can satisfactorily explain the many dimensions to the question. Thus, I hereunder revisit the dominant perspectives that may explain the legal and meta-legal issues that concern MHRs.

The natural law perspective regards human rights as those handed over by God or discernible by human reason. Human rights are viewed in terms of metaphysics and the supernatural (Acquinas, quoted in Harvey, 1975). Natural law theorists view constraints such as poverty, inequality and gender relations as natural, inevitable, biologically determined and God-ordained (Luther, 1962). Undervaluing a woman's unique role and ignoring her rights is deeply embedded in tradition and religion, which are given force by natural law which asserts that the male is naturally superior to the female. However, the natural law perspective cannot be discarded outright. Most of the human rights as are known today derive their origin from natural law (Hannum, 1998). Consequently, some of the humanizing values of natural law can be utilized.

The legal positivist perspective takes a legalistic approach to phenomena (Chambers, J.B, 2011). Legal positivism advocates for the analysis of legal concepts without inquiring into the interplay between law and social, economic and political forces, yet, as Osita-Eze (1979: 50) correctly observed,

If one accepts the thesis that law is essentially a dependent variable, then any proper appreciation of the right to health [read, MHRs],

must concern itself with all the social, political, economic and cultural factors that determine and shape it....

Legal positivists argue that social, economic and cultural rights, such as MHRs, are not rights because they do not pass the justiciability test (Kelsen, 1967). According to Kelsen (quoted in Llyod, 1972: 672),

Pure theory of law means that it is concerned solely with that knowledge which deals with law, excluding from such knowledge everything which doesn't strictly belong to the subject-matter of law.

Legal positivists further argue that in the administration of justice, judges should exercise judicial restraint; they should enforce the law as it is, but not as it ought to be. It should be noted that law can facilitate change or hinder it; it can act as a means of liberation and at the same time as a means of the reproduction of an oppressive social order (Twinomugisha, 2015: 3). Thus, a strict adherence to the law *per se*, though helpful, is not sufficient in answering why realization of MHRs remains elusive.

The sociological perspective, unlike legal positivism, looks at law as a function of society. The perspective advocates for the sociological study of law in preparation for law-making (Pound, 1954). Sociological theorists call for a scientific inquiry into the social, economic and political aspects of the problem that is thought to call for legal regulation. The perspective looks at law as an instrument of social engineering; a facilitator of change (Pound, 1942). Although the sociological perspective is good for the examination of some of the dimensions of the question under discussion, it does not adequately explain the root causes of non-realization of MHRs, which are largely structural and systemic in nature.

Critical legal scholars emphasize the open-ended character of the social and political context in which substantive law is shaped. The critical legal scholars, unlike the legal positivists, recognize the context in which the law is shaped. But not all pay strong attention to the social, political or economic influences on the nature of law. Some critical legal scholars argue that social power rests with the state and not in the people who compose it (Cable & Harris, 1982-1983). A perspective which overemphasizes the role of the state is inadequate given that the state in Africa is largely patriarchal (Gordon, 1996) and has retreated in the area of social welfare following the World Bank and International Monetary Fund (IMF) neo-liberal policies, which were imposed on Uganda (Jjuuko, 1995; Twinomugisha, 2007). In any case, non-state actors control and direct critical

aspects of women's health rights such as access to maternal health care. The state, which as Karl Marx (1848) observed, is but the management of the common affairs of the bourgeoisie, alone may not be entrusted with the realization of women's health rights generally and MHRs in particular.

The modernization perspective, which has for some time been strongly favoured by the World Bank and the IMF, has had a very narrow and static perception of developmental issues (Stiglitz, 2002). The perspective champions the creation of an enabling environment, whereby those who are able to, can utilize the available infrastructure and services such as health care (Turshem, 1984; Hyden, 1994). That with such an environment, the 'rational peasant' would make his or her own decisions in a voluntary fashion (Samuel, 1979). The modernization perspective is underpinned by neo-liberalism, which advocates for the supremacy of free-market policies, but fails to realize that without addressing the underlying forces of patriarchy and underdevelopment, women cannot benefit from such policies (Gordon, 1996). Although the 1990s marked a "paradigm shift" ostensibly towards recognizing the interests of the poor, the major interest is still stability. The argument is that in order to implement economic reform, democratization can wait; the state must resort to short-term authoritarianism, repression and benevolent dictatorship (Nabudere, 1990). Some critics have correctly pointed out that for the poor, development or modernization has always meant the progressive modernization of their poverty (Hellinger *et al*, 1988). In my view, realization of women's health issues such as MHRs requires a democratic approach that recognizes gender inequalities, which cannot be eliminated by the market in absence of other interventions—juridical, administrative and other measures.

Influenced largely by the Marxist philosophy, the dependency perspective argues that the scope and content of a given right are determined by the material living conditions of society – economic, political, social, moral and cultural (Kanji & Manji, 1991). Karl Marx argued that every society, whatever stage of its economic development, rests on a mode of production, which has two important elements: the forces of production and the social relations of production. Marxist theory of law views law as part of the superstructure influenced by the economic base. That law is one form of politics, and law and the state are closely connected. Law gives effect to the prevailing economic relations and it is always potentially coercive and manifests the state's monopoly of the means of coercion (Hunt, 1999). Thus, the objective conditions prevalent in society and the level of development of productive forces have a strong influence on the realization of

a given right. Philosophers such as Maurice Cornforth (1979: 1) also correctly argued that poverty and inequality are not natural but are determined by dialectical material conditions of society and they follow a causal sequence since,

Nothing exists or can exist in splendid isolation separate from the conditions of existence, independent of its relationships with other things. Things come into being, exist and cease to exist, not each independent of all other things, but in relationship with other things.

The dependency perspective sharply criticizes the dependence of underdeveloped countries on the metropole, and challenges neo-liberal globalization and its marginalization of the poor (Amin, 1990; 1994). The perspective rejects as a myth the view that underdevelopment can be liquidated merely through economic growth or modernization promoted by capitalism through foreign aid or foreign investment, and other diffusions from developed countries (Twinomugisha, 2008). Although some dependency theorists view human rights as an ideological expression of bourgeois egoism and social automation and part of the ideology of imperialism, they recognize that the human rights corpus can be a political asset in the struggle against oppression in exploited societies (Shivji, 1989; Mutua, 1997).

In my view, the dependency perspective seems to offer a realistic explanation of the problems of underdevelopment. However, the perspective tends to put all the blame for our ills on external forces. The perspective does not adequately question internal factors critical to maternal health such as how the state prioritizes and allocates the available resources and the role of patriarchy and gender relations. For as Elson (1991: 43) has pointed out, although the dependency perspective recognizes that the impact of foreign capital is mediated by internal class structures, it is not widely recognized that it is also mediated by internal gender relations such as the sexual division of labour and dependence in the home. Although some dependency theorists advocate for changing the mode of production, this, as Gordon (1996: 114) correctly observes, may not change the relations of production in which men often have authority over women's labour and house-hold income and control over critical resources. By privileging class domination, the dependency perspective marginalizes the analysis of sex relations within social groups (Edholm *et al*: 1982). These issues, as this lecture illustrates, are crucial in the discussion of the extent to which MHRs are realized.

The human rights perspective has been sharply criticized. It has been argued that because of the dichotomy between the public and private spheres, and because

of the highly artificial substantive rules of process and evidence involved, the perspective may decontextualize social realities leading to the non-recognition of violations of human rights especially of the poor (Taylor 1992: 301; Mutua, 1997; Langlois, 2012; Marks, 2013). However, the use of rights language vis-à-vis social goals confers a special status on the goals. As Dworkin (1992) observes, human rights are avenues through which powerless and disenfranchised individuals and groups can claim and eventually enforce equality. Dworkin (1992) further argues that categorizing something as a right means the right 'trumps' many other claims or goods. The human rights perspective can be empowering (Golder, 2014), since '[t]he purpose of human rights is to democratize empowerment and entitle each person to claim as a right what historically the powerful could enjoy as a privilege' (Cook, 1994: 80).

The human rights perspective provides a useful tool for determining a state's responsibility and accountability. Recognition of health as a human right provides legal and political legitimacy to the claims for its enjoyment. Recognizing maternal health as a human rights issue emphasizes that it is of special significance given its impact on the life and survival of women, their children and families. Rather than dismissing or abandoning the human rights perspective, therefore, it should be reconstructed so that it specifies gender, class, culture and other differences and recognizes social needs (Twinomugisha, 2004). Jochwick (1997: 80) aptly summarized the utility of the human rights perspective as follows:

Rights rhetoric provides a mechanism for reanalyzing and renaming "problems" as "violations", something that needn't and shouldn't be tolerated.... Rights make it clear that violations are neither inevitable or natural, but arise from deliberate decisions and policies. In their demands for explanations and accountability, human rights expose the hidden priorities and structures behind violations. Thus, the demystification of human rights, both in terms of their economic and social content, and their applicability to non-state actors, constitutes a critical step towards challenging the conditions that create and tolerate poverty.

The gender perspective situates maternal health in the context of everyday life, be it law, economics, politics, religion and culture. The perspective recognizes that gender relations are based on differential relations of power, in which patriarchy and underdevelopment exert substantial control and influence over women. The perspective takes into account the ways women cope with social, economic and cultural constraints (Vlassoff, 1994; Twinomugisha, 2012).

However, the western concept of gender has been criticized as reflecting the Northern view of sexual division of labour and does not therefore adequately capture the multiple roles of women in underdeveloped countries (Moon: 1988; Tamale, 1999; Twinomugisha, 2012). In underdeveloped countries like Uganda, class variables intersect with gender to compound the complexity of power relations (Okeyo: 1981; Odim: 1991; Tamale: 1999; Twinomugisha, 2004). I agree with the foregoing critics that the Western concept of gender should not be uncritically projected onto the Ugandan society. Gender analysis in the Ugandan context must take into account the fact that the internal domestic structure of a single Third World nation is increasingly determined by the political economy of international law and relations (Hills, 1994; Twinomugisha, 2012).

For an effective analysis of the issues under discussion, the gender perspective must take into account the economic status of Ugandan women, given the pivotal role they play in the economy and how they are marginalized and excluded from its benefits. As Odim (1991) has pointed out, gender discrimination as postulated in international human rights instruments is quite relevant, but we should not ignore the fact that Third World women are struggling daily with their communities and men against poverty and economic exploitation. The Western gender perspective can be applicable to Uganda and African societies with the necessary modifications because as Tamale (1999: 31) has correctly observed, the general social and legal structure of post-colonial African states is based on a Western model, and as in Western societies, the division of labour in Africa has been mainly based on sex. The gender perspective highlights and exposes hierarchical and unequal relations and roles between males and females, the unequal value of women's work, and women's unequal access to power and decision making as well as property and resources (Twinomugisha, 2012). The gender perspective must challenge the neo-liberal economic model that emphasizes the market economy, which is underpinned by growth and accumulation, to the detriment of the poor who cannot afford maternal health care.

Thus, the perspective employed in this lecture attempts to situate and locate the discussion within the broader juridical, political, economic, social and cultural framework of our society. What is required is a dynamic and integrated perspective which expands the target of action beyond the state to encompass non-state actors. Consequently, the theoretical perspective in which I locate, view and examine MHRs, politics and the law in Uganda is integrative – a combination of the dependence, human rights and gender perspectives within

the parameters indicated in the discussion above. In the next section, I briefly examine the normative content of MHRs and the attendant obligations of the state and non-state actors.

MHRs, Obligations of the State and Non-state Actors

Understanding Maternal Health

It should be pointed out from the outset that there is no definition that can be both precise and sufficiently broad to encompass all aspects of maternal health. However, according to WHO, maternal health ‘refers to the health of women during pregnancy, childbirth and the post partum period’.¹⁵ This definition underlines the fact that for a woman to safely go through pregnancy, labour and delivery, she should be healthy. Maternal health is indeed a core component of health, which is defined by WHO as a ‘state of complete physical, mental and social well-being and not merely the absence of disease and infirmity’.¹⁶ Thus, maternal health moves beyond maternal health care – antenatal care, labour and delivery care, and family planning – and encompasses all aspects of a woman’s physical and mental health and well-being during pregnancy, child birth and the post natal period.

Maternal health is protected in legal and policy frameworks because of women’s unique maternal functions in society. Thus, although men play a critical role in women’s lives, MHRs are largely specific to women. As Tomasevski (1985: 80) observed, it is a biological fact that women bear children and men do not, and thus,

Societal and legal protection aims to compensate for this biological difference and accords protection to women. This protection derives from the acknowledgement that child bearing and child rearing is a societal function, hence compensation is earned by women who perform it; it is not granted to them for the mere fact that they are women.

15 WHO, ‘Maternal Health’, available at http://www.who.int/topics/maternal_health/en/ (accessed 9 January 2017).

16 Constitution of the World Health Organization 14 UNTS 185.

Fathalla (1988: 4) also observed that since women are entrusted with the survival and propagation of human species, they have a basic right to be protected when they risk their health and life in the process of giving us life. The Universal Declaration of Human Rights (UDHR) also declares that '[m]otherhood and childhood are entitled to special care and assistance'.¹⁷ The Constitution is also clear: in protection of women and their rights, the state shall take into account their 'unique status and natural maternal functions in society'.¹⁸ In any case, pregnancy and childbearing increase the risk of mortality over and above the general population. WHO has aptly captured the double-edged experience of motherhood: while it 'is often a positive and fulfilling experience, for too many women, it is associated with suffering, ill-health and even death'.¹⁹

MHRs as Human Rights

MHRs are a critical component of the right to health, which is protected in international, regional and domestic instruments. WHO guarantees health as a fundamental human right (WHO Constitution, 1946). The ICESCR enjoins states to take steps to realize the 'right of everyone to the highest attainable standard of physical and mental health'.²⁰ One of the steps to be taken by states towards realization of the right to health is the '[t]he provision for the reduction of the still birth rate and infant mortality and for the healthy development of the child'.²¹ The Committee on Economic, Social and Cultural Rights (CESCR), which monitors state compliance with the ICESCR, has interpreted this provision to oblige states parties to take measures 'to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre-and post natal care, emergency obstetric services, access to information, as well as to resources necessary to act on that information'.²² States should take measures to reduce women's health risks especially lowering the rates of maternal mortality and the removal of all barriers interfering with access to health services.²³

Another treaty, which specifically deals with women's human rights and contains provisions with a direct bearing on MHRs, is CEDAW. It obliges states parties to 'take all appropriate measures to eliminate discrimination in the field of health

17 Art 25(2).

18 Article 33(3).

19 WHO, *op cit*, note 15.

20 Article 12(1).

21 Article 12(2)(a).

22 Para. 14.

23 Para. 21.

care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning'.²⁴ The Convention also enjoins states parties to 'ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation'.²⁵ The Convention urges states parties to pay special attention to rural women and ensure that they, amongst other things, have 'access to adequate health care facilities, including information, counseling and services in family planning'.²⁶

The CRC, which specifically addresses children's rights, guarantees every child the right to the enjoyment of the highest attainable standard of health and obliges states parties to 'ensure appropriate pre-natal and post-natal health care for mothers'.²⁷

At the regional level, the ACHPR guarantees the right to the best attainable state of physical and mental health²⁸ and obliges states parties to 'take measures to protect the health of their people and to ensure that they receive medical attention when they are sick'.²⁹ The Women's Protocol to the ACHPR, which is the first treaty to specifically address human rights of women in Africa, enjoins states parties to ensure the respect and promotion of women's health rights including the right to control their fertility; the right to decide whether to have children, the number of children and spacing of children; the right to choose any method of contraception; and the right to family planning education.³⁰ The Protocol is also the first treaty to recognize legal and safe abortion under certain circumstances as a woman's human right, which she should enjoy without fear of prosecution. States parties are obliged to 'take all appropriate measures to 'protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or fetus'.³¹ Commenting on these provisions, pursuant to its mandate under the ACHPR to 'formulate and lay down principles and rules aimed at solving legal problems relating to human rights',³² the African Commission on Human and Peoples' Rights (hereafter: 'African Commission') has stated that women should

24 Article 12(1).

25 Article 12(2).

26 Article 14.

27 Article 24(1).

28 Art 16(1).

29 Art 16(2).

30 Article 14(1)(a)-c) and (g).

31 Article 14(2)(c).

32 Article 45(1).

be informed of safe abortion related products, procedures and health services.³³ The African Commission has also stated that women's right to be free from discrimination, which is guaranteed under the Protocol, also means that,

[women] must not be subjected to criminal proceedings and should not incur any legal sanctions for having benefited from health services that are reserved to them such as abortion and post abortion care. Furthermore, it entails that the health personnel should fear neither prosecution nor disciplinary reprisal or others for providing these services, in the cases provided in the Protocol.³⁴

States parties should ensure that women who seek reproductive health services such as family planning or safe abortion and post abortion care 'are not treated in an inhuman, cruel or degrading manner'.³⁵

The African Charter on the Rights and Welfare of the Child guarantees every child the right to enjoy the best attainable state of physical, mental and spiritual health³⁶ and obliges states parties to take measures to reduce infant and child mortality rates in addition to provision of appropriate health care for pregnant women and nursing mothers.³⁷

At the domestic level, both the right to health and MHRs are not explicitly provided for in the Bill of Rights of the Constitution of the Republic of Uganda. However, it contains provisions with a bearing on MHRs. The Constitution enjoins the state to promote social well-being of the people and in particular to ensure that all Ugandans enjoy rights and opportunities and access, amongst other things, to health services.³⁸ The state is also obliged to take all practical measures 'to ensure the provision of medical services to the population'³⁹ and 'to encourage and promote proper nutrition'.⁴⁰ The Constitution also contains a number of human rights and freedoms, which are critical for the protection of MHRs, given the interdependence, indivisibility and interrelationship of human rights. These include: equality and freedom from discrimination,⁴¹ the right to life,⁴² respect for human dignity and 'prevention from torture or cruel, inhuman or degrading

33 General Comment 2, para. 31.

34 General Comment 2, para. 32.

35 General Comment 2, para. 36.

36 Art 41(1).

37 Art 14(2).

38 National Objective and Directive Principle of State Policy (NODPSP), Objective XIV.

39 Ibid, Objective XX.

40 Ibid, Objective XX1.

41 Art 21.

42 Art 22.

treatment or punishment,⁴³ and women's human rights.⁴⁴ The Constitution also recognizes other human rights such as MHRs, which are protected in the international and regional human rights instruments outlined above, but are not explicitly mentioned in the Bill of Rights.⁴⁵

State Obligations

Like with other human rights, the state has three types of obligations: to respect, protect and fulfill the right to health generally and MHRs in particular. The obligation to respect requires the state to refrain from interfering directly or indirectly with the enjoyment of MHRs. The obligation to protect requires the state to take measures that prevent third parties from interfering with the enjoyment of MHRs. The obligation to fulfill requires the state to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the realization of MHRs. The obligation to fulfill also requires the state to take positive measures to assist individuals or groups who are unable by the means at their disposal to realize MHRs.⁴⁶ The state should ensure the availability, accessibility, acceptability and quality of maternal health care services.⁴⁷

The state's obligations are to be realized progressively in accordance with the available resources. However, there are obligations, which are of immediate effect: the guarantee that MHRs will be enjoyed without discrimination of any kind;⁴⁸ and the obligation to take steps towards realization of the right. The steps must be deliberate, concrete and targeted towards realization of MHRs. Thus, the concept of progressive realization should not be interpreted as depriving the state's obligations of any meaningful content. States have a continuing obligation to move as expeditiously as possible towards the full realization of MHRs. Retrogressive measures are not permitted unless the state justifies that it took the decision after seriously considering all alternatives.⁴⁹

43 Art 24 and 44.

44 Art 33.

45 Art 45.

46 For an elaborate discussion of these obligations, see Committee on Economic, Social and Cultural Rights, General Comment No. 14: 'The Right to the Highest Standard of Physical and Mental Health' HRI/GEN/1/Rev 9 (Vol I) (2000) paras 34-36; General Comment No. 22, 'The Right to Sexual and Reproductive Health (article 12 of the International Covenant on Economic, Social and Cultural Rights) (2016), paras 40-48.

47 Para 12 General Comment 14; Paras 11-21 General Comment 22.

48 Paras 22-24 General Comment 22.

49 See paras 30-32 General Comment 14.

Obligations of Non-State Actors

The state has the primary responsibility to respect, protect and fulfill human rights, including MHRs. Under the obligation to protect, the state is obliged to ensure that activities of non-state actors do not violate MHRs of its citizens. The question is: do non-state actors have obligations to protect MHRs? To what extent can they be held liable for violations of MHRs? The horizontal application of human rights to non-state actors is an evolving and contested legal arena both at international and domestic levels (Aoife, 2014; UCCA, 2016). However, in Uganda, the Constitution is clear: non-state actors have human rights obligations and can thus be held accountable. The Constitution provides that the rights and freedoms in the Bill of Rights ‘shall be respected, upheld and promoted by all organs and agencies of Government *and by all persons*’.⁵⁰ The phrase ‘by all persons’ certainly includes natural and artificial persons. Thus, accountability for violation of MHRs moves beyond the state and encompasses other actors, including private health providers and international institutions such as the World Bank, the International Monetary Fund (IMF) and the World Trade Organization (WTO), who are the key architects of neo-liberal policies. This constitutional provision is critical in the struggle for realization of MHRs given that most violations of women’s human rights occur in the so-called private sphere – family, community, institutions and the market.

50 Article 20(2).

4

Causes of Non-realization of MHRs

It can be seen from the above discussion that MHRs are now firmly established in international and regional human rights instruments, which Uganda has ratified and in the Constitution. It is also clear that both the state and non-state actors have obligations to protect and uphold these rights. In spite of the theoretical legal recognition of MHRs and the attendant obligations, realization of these rights remains elusive. The causes of non realization of the rights in question and the resultant maternal mortality and morbidity in Africa in general and Uganda in particular are complex and multifaceted. Consequently, this section attempts to unravel the immediate and structural causes of non realization of MHRs in Uganda.

Immediate Causes, Interventions, and Barriers to Access

The immediate causes of maternal mortality and morbidity include; post-partum hemorrhage (uncontrolled bleeding), hypertensive disorders (eclampsia), sepsis (infection), prolonged or obstructed labor, complications of unsafe abortion and concurrent diseases such as HIV or malaria and a lack of access to critical components of maternal health care such as family planning, skilled health personnel and EmOC (Freedman et al, 2005). Interventions to reduce maternal mortality and morbidity include increased access to family planning services, enhanced access to high quality comprehensive EmOC, skilled health care personnel, and access to safe legal abortion for all women desiring elective termination of pregnancy. Health facilities should also have basic maternal health commodities such as blood, gloves, oxygen, and power. For example, in Mexico, a strategy that increased coverage of family planning by 15 per cent and assured access to safe abortion for all women desiring elective termination of pregnancy reduced maternal mortality by 43 per cent (Delphine Hu, et al, 2007). Enhanced access to comprehensive EmOC for at least 90 per cent of women requiring referral, reduced mortality by 75 per cent (ibid).

Some of the barriers of access to and utilization of these maternal health care services include: cost, access, infrastructure, quality and sustainability of care, and information deficit and attitudes. Women may also delay to seek appropriate medical care in time; delay in reaching adequate health facility; and delay in receiving health care at the facility (Thaddeus & Maine, 1994). For women seeking maternal health care, costs include those for facilities and services, and involve both formal and informal fees, the cost of drugs and equipment, transport to a hospital or clinic and the opportunity costs of getting to a health facility and receiving care (Twinomugisha, 2004). Poverty is thus a barrier to realization of MHRs and is an immediate cause of maternal mortality and morbidity as it prevents many women from getting proper and adequate medical attention. But the question is: why are the women poor and vulnerable? In other words, what are the structural or root causes of poverty and inequality? Women are part of the political, economic, and social structures of society and the culture that informs them (Twinomugisha, 2004; Navarro, 2007). So, what are the structural links between maternal health and the economic, political, social life of women?

Structural Causes of Non-realization of MHRs

Neo-Liberalism

According to Coburn (2000), neo-liberalism refers to the dominance of markets and the market model and is based on a number of assumptions: that markets are the best and most efficient allocators of resources in production and distribution; that societies are composed of autonomous individuals – producers and consumers – motivated largely or entirely by material or economic considerations; that competition is the major market vehicle for innovations; and that a welfare state interferes with the normal functioning of the market (Coburn 2000: 136). Coburn (2004) also points out that according to the neo-liberalists, the state should not interfere in markets, their imperfections notwithstanding. That access to social services such as education and health should largely be left to the invisible hand that aligns production, consumption and distribution (Coburn, 2001; Coburn, 2014).

Neo-liberal thinking emphasizes individual choice in the market place combined with limited government involvement in the economy. Neo-liberalism demands that there should be minimal interference by the government, whose role should be limited to promoting an environment in which property rights are respected and the money supply is stable (Melissa, 2004). The design and implementation of social policies for example on health should be to support the

market. Privatization is a core component of neo-liberal thought: governments are viewed as incapable of doing business (Coburn, 2003; Coburn, 2010). These neo-liberal assumptions are disastrous. The so-called economic growth has co-existed with poverty and increased inequalities between the rich and poor.

Neo-liberalism and Maternal Health

Social Welfare Interventions: From Colonialism to the Immediate Post Independence Period

Before delving into the dynamics of neo-liberalism and its ramifications for MHRs in Uganda, it is necessary to provide a brief historical note to the discussion. The current state can be traced to 1894 when Uganda was declared a British protectorate. The colonial state was created and sustained by the force of arms. As a state of conquest, it displaced, distorted and suppressed pre-colonial state institutions, which were largely based on consensus. According to some commentators, the colonial state was 'elitist, centrist and absolutist' (Wusnsh & Olowu, 1990). Authority was concentrated in the colonial administration without popular participation. Although the African post colonial state took on some elements of the colonial state, especially in the suppression of civil and political rights and freedoms, immediate post independence leaders invested in the socio-economic development of the citizens. For example, in the 1960s and early 1970s, in pursuance of its obligations, the Ugandan government heavily invested in the provision of social services such as education and health care. These were viewed as public goods relatively accessible by everybody, including the poor.

The role of the market in the provision of social services was not pronounced like it is today. In any case, most of the private facilities were owned by faith-based organisations, which offered relatively cheap services. The poor were largely serviced by public facilities. Health was taken as a major priority for human survival. The state regarded it as an obligation to invest in human development, including essential sectors such as health. It built hospitals and other health facilities and ensured that they were equipped with medicines and other health care related products. Health workers were well remunerated and highly motivated in order to professionally carry out their work. Agricultural services were extended to the people to ensure self-sufficiency in food, which is an essential component for health and well-being. For example, as I was growing up in Rukiga, Kabale, South Western Uganda, it was common to see agricultural extension workers moving in rural areas educating people about how to cultivate and care for their crops. Even during the military dictatorship of Idi Amin (1971-

1979), which was generally a period of scarcity, every home was obliged to have a granary, which would periodically be inspected by a chief to ensure that the family is well-guarded against hunger and famine. Families, including pregnant women, were assured of food.

Enter Structural Adjustment Programmes

In the 1980s, the state adopted World Bank and International Monetary Fund (IMF)-inspired neo-liberal Structural Adjustment Programmes (SAPs), which dictated the supremacy of the market in the provision of socio-economic services (Stiglitz, 2002: 2) and were geared at promoting the interests of the developed countries to the detriment of those of the underdeveloped countries. SAPs included privatisation, cutbacks in public spending, dismantling of social welfare, retrenchment of the formal labour force and deregulation of labour markets. According to the World Bank and IMF, the state had to withdraw from the provision of these services and concentrate on creating the so-called enabling environment so that people could provide for themselves. Consequently, like a magic wand, SAPs would spur growth, whose benefits would trickle down to the poor, thereby leading to development. This view was of course wrong. There is a world of difference between growth and development. Growth is quantitative and generally refers to the Gross Domestic Product (GDP), whose yardstick is per capita income, which takes the total income of the rich or wealthy and divides it amongst the population. On the other hand, development is qualitative and generally refers to the quality of life of the people. It is therefore highly possible to have high figures of growth with many poor people lacking access to basic services such as maternal health care.

Following pressure from civil society and the realisation by the World Bank and IMF that SAPs had simply caused artificial growth and miserably failed to enhance development and had in fact plunged poor countries into further debt and poverty, these financial institutions introduced the so-called Poverty Reduction Strategy Papers (PRSPs), which were a precondition for qualification for debt-relief. Since 1997, Uganda has embraced these PRSPs, the recent being the Poverty Eradication Action Plan (PEAP), which has been replaced by the National Development Plan (NDP) and Vision 2040 (Republic of Uganda, 2010; 2013). The NDP does not seriously question the neo-liberal macro-economic framework that guided the imposition of SAPs on the country and the eventual development of the PEAP.

The so-called decrease of poverty levels from 31 percent in 2006 to 19.7 percent in 2016 (World Bank, 2016) is cosmetic: it masks the growing inequality between the rich and the poor. Data about poverty must not be taken on face value. For example, whereas there was more rapid reduction of poverty in the Western region, most of the poor were concentrated in Northern and Eastern regions where poverty levels increased from 68 per cent in 2006 to 84 per cent in 2016 (ibid). It should even be pointed out that the World Bank's measure of poverty, which focuses on income levels and access to basic needs, ignores important aspects of poverty such as empowerment, intra-household gender dynamics, and exercise of democratic rights (Thomas, 2010). One does not need to be an economic expert to realize that economic inequality is getting more extreme, with those at the top getting richer while the majority are finding life increasingly harsh. Economic growth without genuine state intervention to tame the market is insufficient to lift people out of poverty. People simply put on a brave face, as my aunt cynically remarked above: 'The poor do not fall sick', when in fact they are groaning in pain.

I have argued elsewhere that like the PEAP, PRSPs are simply a reincarnation of the discredited SAPs, which negatively impacted on the realisation of socio-economic rights such as the right to health (Twinomugisha, 2008). In fact, a careful reading of the NDP and Vision 2040 shows that the private sector – the market – is still viewed as the engine of growth, including the provision of socio-economic services. Like the Plan for Modernisation of Agriculture (PMA), the NDP and Vision 2040 promote the so-called modernisation or commercialisation of agriculture, instead of self-sufficiency in food, which ensures proper nutrition – an essential requirement for good maternal health. Although the NDP and Vision 2040 recognise health and agriculture as priorities for the development of the country, they attract limited funding from the state. For example, health attracts only about 9 per cent as against the agreed upon Abuja Declaration target of 15 per cent⁵¹ while agriculture takes 2-3 percent of the national budget.

Neo-liberal economists who advocate for privatisation of social services argue that increasing funding for socio-economic services like health has inflationary tendencies, which are likely to affect the economy (Marc, 1989: 179). This is of course wrong given that a healthy population is a pre-requisite for growth and development of the economy. SAPs simply breed state patronage and corruption

51 The heads of state of the African Union met and pledged to set a target of at least 15 per cent of their annual budget to improve the health sector. See, para 26 of the 'Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases' http://www.un.org/ga/aids/pdf/abuja_declaration.pdf (accessed 20 March 2013). See also, WHO 'The Abuja Declaration: Ten years on' <http://www.who.int/healthsystems/publications/Abuja.pdf> (accessed 24 March 2013).

and thus have deleterious consequences for the right to health generally and MHRs in particular by diverting public resources to private use.

Neo-liberal policy frameworks have also worsened the debt burden. Although Uganda qualified for debt relief under the Highly Indebted Poor Countries (HIPC) programme, as a result of implementing PRSPs, the relief could not bring tangible benefits to the economy but ensured that the country increased spending on poverty reduction leading to future build up of the debt. The external debt rose from \$ 4.361 billion in 2014 to \$ 7.6 billion in 2015.⁵² The debt significantly increased to 30.5 per cent of GDP as of June 2013 from 20 per cent in 2006/7 (Republic of Uganda, 2015: 1). Resources that would have been spent on critical areas of human development such as maternal health are diverted to debt repayment. Increased external debt means that a significant share of the income of Uganda is used to pay back the debt often with crippling interest rates. Debt burden results in a net outflow of resources from rich to poor countries thereby worsening the already unfair terms of trade. The future of the present and future generations is mortgaged to the international financial system.

On the question of debt, a word of caution is in order. Borrowing is not a problem as such since the country may not easily depend only on internally generated resources. In any case, states can, through international financial assistance and cooperation, enhance the realization of MHRs. However, the question is: what is the money spent on? Are the borrowed funds spent on productive sectors such as health and agriculture? In my view, the external debt is a real obstacle to realization of human rights, especially if the borrowed funds are spent on non-productive sectors.

The question is: what does the above narrative mean for the right to health generally and MHRs in particular? Privatisation, or simply put, having the market play a dominant role in the provision of social services, has negative consequences for MHRs. By definition, the poor lack the necessary income for purchasing maternal health care goods and services. Because they cannot afford, they are denied access to safe, appropriate high quality maternal health care especially labour and delivery care and EmOC, which are majorly provided by private persons. Only the ruling class and the wealthy can afford private services

52 CIA World Fact Book: Uganda External Debt, http://www.indexmundi.com/uganda/debt_external.html (accessed 16 January 2017); Didas Kisembo, 'Is Uganda's national debt sustainable?' *Daily Monitor Newspaper*, 3 June 2015; Apollo Mubiru, 'Uganda's outstanding public debt hits \$7.6 billion' *Daily Monitor Newspaper*, 11 June 2015 compared to \$7.2 billion in 2014; Barbara Among, 'At \$ 7 b, Uganda's debt worries Parliament', *The East African Newspaper*, 9 August 2014.

at places such as Nakasero Hospital and International Hospital Kampala. Even missionary founded and faith based hospitals such as Mengo, Rubaga and Kibuli are beyond reach of the poor. As the Committee on ESCR has observed, a poor person's situation may result in discrimination and the denial of crucial services such as health care.⁵³

It should be pointed out that even public referral institutions such as Mulago hospital in Kampala, have both the so-called private and public sections of health care provision. The private wing has the best consultants and doctors who attend to private patients. Patients in this section are provided with all types of care including relatively good food. Indeed, there are two worlds in Mulago hospital: one for the rich and the other for the poor. In the general wards, the situation is pathetic and disturbing. The services are poor, the drugs are generally not available and patients are asked to purchase them elsewhere. Pregnant women at Mulago or other public hospitals, who are waiting for their turn to go to the labor suite, sleep on the floor. To its credit, government is renovating and refurbishing Mulago Hospital but it is doubtful whether the services therein will be affordable by the poor. I recently visited Mparo Health Centre IV in Rukiga Sub-county, Kabale District. Government has constructed some buildings at the health centre, but there is no assured electricity or solar power and basic maternal health commodities. Like in many other parts of the country, the workers at the health centre are also overworked and poorly remunerated. Instead of addressing the challenge of health workers' remuneration, some health officials are advocating for user fees in order to raise the workers' salaries.⁵⁴

It is entirely wrong to treat health care as a commodity to be regulated by the forces of demand and supply. Reliance on market forces by privatising health care ignores the reality that the poor lack sufficient income, and thus access to the market where health care is bought and sold is restricted. It is a fallacy to assume the neutrality of the market. Privatization of health services has a detrimental impact on women and contributes to high rates of maternal mortality. The argument by the World Bank (1987) that user fees would improve efficiency and equity by increasing revenues to the health care system and enhance quality and coverage of medical care is simply a red herring. In any case, without a

53 Committee on ESCR, General Comment 20 'Non-discrimination in economic, social and cultural rights' (art 2, para 2 of the International Covenant on Economic, Social and Cultural Rights) Forty-Second Session, Geneva, 4-22 May 2009, E/C.12/GC/20 para 35.

54 See for example, Violet Nabatanzi, 'Mulago wants patients to pay user fees' *Sunday Vision* Newspaper, 1 January 2017.

welfare-oriented state, market relationships tend to favour those already richer and better endowed. Promoting privatisation or commercialisation of health-related services as a substitute for provision of public services, which have been eroded by the neo-liberal economic framework, is illusory.

Health related services are not like ordinary commercial goods or commodities which can be left to the control of market forces. The market, its imperfections notwithstanding, is left to dictate the prices of health care goods and services without state intervention. The majority of the population cannot afford fees and other charges at private health facilities, given that they have to spend on other social services such as education, whose provision has been abdicated by the state. Privatization of health services does not increase access for poor women. Private, for-profit health services are more interested in profits than access and equity. Commercialization and privatization of health care must be reversed.

Neo-liberalism has increased the power of business classes and lowered that of the working classes, including poor women. It has increased income inequality and poverty, leading to unequal access to many health relevant resources. Poverty and the resulting material and social deprivation for families and communities have a strong impact on maternal health outcomes (Conburn, 2014). Systemic, policy created poverty and inequality are at the heart of material deprivation and have sustained erosion of health and wellbeing of citizens including expectant mothers. This situation is exacerbated by a lack of access to a socialized welfare health care system. Freedom from non-discrimination, which underlines the fact that all citizens are entitled to human rights, including the poor and geographically disadvantaged, is compromised. From a human rights perspective, privatization of maternal health services, which includes charging fees for consultation, hospital bed, blood or laboratory tests, labor, delivery, medicine and other charges, fails to secure the rights to non-discrimination, health and life, which are guaranteed in the Constitution and human rights instruments that Uganda has ratified.

Unfortunately, the above sad state of affairs is backed by the law, which as Marxists correctly argue, is an instrument of the ruling class and their local and international capitalist allies. For example, the Medical and Dental Practitioners' Act⁵⁵ and the Nurses and Midwives Act⁵⁶ empower private health care providers, who are regulated by these laws, to levy reasonable charges for services

55 Cap 272 Laws of Uganda, sec 42.

56 Cap 274 Laws of Uganda, sec 49.

rendered including the sale of drugs and enforce recovery of the same in courts of law. However, there is neither a legal instrument nor yardstick to determine the reasonableness of the charges. Yet, the state has an obligation to protect the right to health, including MHRs, which require it to take steps to ensure that the activities of private actors do not violate these rights. For example, Tanzania has passed a legislation, which empowers the minister to regulate the prices charged by private providers of health care goods and services.⁵⁷ Unlike Least Developed Countries (LDCs) such as Rwanda where health insurance has been implemented and is reported to be effectively functioning (McNeil Jr, 2014), in Uganda, those unable to pay for maternal health services in the market have to accept their fate and die or suffer debilitating injuries. The Rwanda government has ensured that about 98 per cent of Rwandans have health insurance and the premiums are small and affordable.⁵⁸

In addition to the bad economic policies considered above, the so-called economic growth has bred unprecedented levels of naked corruption in government in general and the health sector in particular. Graft and corruption are now part of everyday political life at all levels.⁵⁹ Funds meant for health services are diverted and in fact there is a debilitating lack of accountability in the health sector. In one of the scandals in the health sector, funds under the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria were misappropriated. In public health facilities where services are ostensibly supposed to be free, patients are asked to pay for the services. A patient may have to pay a bribe to have a doctor or nurse attend to him or her, and sometimes patients are asked to buy the medication prescribed. Corruption in the health sector can thus lead to death or injury, thereby preventing women from enjoying their MHRs. For example, a mother who allegedly failed to pay 5,000 shillings to a nurse at Mityana Hospital died due to lack of labor and delivery care!⁶⁰

Neo-liberalism has created a patrimonial, crony and kleptocratic state, whose leaders swear by economic growth and seem to view good growth indicators as the main source of their legitimacy (Olowu, 1994; Mkandawire, 1997). The

57 The Private Hospitals (Regulation) Act, Cap 151. The Act, *inter alia*, provides for the control of fees and other charges payable in respect of medical treatment and other services rendered by private hospitals. The Act applies to all private hospitals, which are defined to include 'a dispensary, maternity home, clinic and also any place or premises used for purposes of medical treatment, whether regularly or periodically' (sec 3).

58 See, M.Nyandekwe et al 'Universal health coverage in Rwanda: Dream or reality?' (2014) 17 *Pan African Medical Journal* 232.

59 See for example, Ephraim Kasozi, 'Uganda ranked among top 25 world countries', *Daily Monitor* Newspaper, 26 January 2017.

60 See Jessica Nabukenya, 'Hospital staff arrested over mother's death', *Daily Monitor* Newspaper, 17 February 2017, p. 1.

current state consists of a self interested parasitic class that views politics as a vehicle to hegemonic economic power. The state is controlled and manipulated by the dominant ruling class that is preoccupied with trying to establish its security and control to the detriment of investment in critical sectors of the economy such as maternal health. The leaders are largely interested in self preservation and aggrandizement. Political office is not sought for its own sake but for material advantage. Politics has become more like business: it has been commercialized. Political opponents are co-opted into the ruling class and allowed to enrich themselves through public office.

There is also a bloated public administration composed of ministers, presidential advisors, presidential assistants, presidential secretaries, Resident District Commissioners (RDCs) and their deputies, district chairpersons, district speakers, local councilors. The cost of public administration inhibits policy actions to bring about dramatic changes in the socio-economic conditions of the majority of the population. Members of Parliament (MPs), who number 427, are each entitled to a consolidated pay of between 20 and 25 million shillings, and other benefits monthly, including a one off car grant of over 150m, wardrobe grant and travel allowances.⁶¹ MPs recently passed a law to exempt themselves from paying taxes on their emoluments! In a scandal that recently shocked the nation, the President decided to selectively reward a few public servants for executing their public duty – representing Uganda in an oil tax dispute case – with 6 billion shillings.⁶² These resources can have a significant impact on women's health if they are invested in critical areas such as EmOC or paying public health workers who are forced by SAPs to adopt multiple strategies in order to survive, including setting up private clinics or going abroad for better pay.

Neo-liberalism requires benevolent states and regimes, which must be market efficient in suppressing and delegitimizing human rights practices. The government prioritizes military and security expenditures in order to ensure regime survival. The World Bank and IMF meekly challenge this type of expenditure provided the regime can safeguard their interests. It is worth noting that the World Bank is a bank and like its counterparts it focuses on profit making. So long as there is some relative stability and an enabling environment in which to carry on their business, the World Bank and IMF will ignore violations of human rights, including MHRs. For example, the World Bank has developed

61 Yasin Mugerwa 'Benefits that await members of 10th parliament', *Daily Monitor* Newspaper, 28 February 2016.URN, 'Parliament to spend shs 64 billion on MPs cars', *The Observer* Newspaper, 8 July 2016

62 Frederic Musisi & Solomon Arinaitwe, 'Shs 9 billion oil bonanza: The inside story' *Daily Monitor* Newspaper, January 5, 2017, pp. 4-5.

its 2016 Environmental and Social Policy Framework, which does not require the bank or its borrowers to respect human rights, ostensibly on ground that doing so would turn it into a human rights tribunal.⁶³ Thus, over the years, classified resources, including donor money, have been spent on wars without any varied interests to the country. These include the invasion of Rwanda, Democratic Republic of Congo, South Sudan and Somalia. According to the World Bank, in 2013, the government spent 10.4 per cent of the national budget on the military (World Bank, 2013). Recently, government spent over \$ 740 million (over 1.7 trillion shillings) on the purchase of military jets.⁶⁴ Without much donor support, it is doubtful whether the ruling National Resistance Movement (NRM) regime would be able to spend as it does on the military.

Whereas it may be understandable that the government must spend on defence to protect citizens' lives and property, the question is: why such expenditure when the country is said to be at peace? The jets are simply displayed on big occasions to instill fear in the citizenry, yet women are dying or suffering injury due to a lack of critical maternal health services. The government also spends a lot of classified resources on the purchase of police equipment including guns, batons, sticks, tear gas canisters, bull-dozers, heavy and light motor vehicles in order to proscribe and suppress dissent using draconian provisions of the 2013 Public Order Management Act, which limits constitutionally protected freedoms of expression, assembly and association. If the money spent on suppressing opposition activities was channeled into maternal health, the maternal mortality rate would have dramatically reduced.

Huge donor resources have since the 1990s poured into Uganda but they are diverted to schemes and activities such as funding intelligence services – formal and informal – in order to ensure regime survival. Although military spending is justified by state bureaucrats in the name of 'state security', it is a fact that a lot of military spending not only hampers socio-economic development, it erodes the democratic political environment required to promote development. In my view, the security of a nation must be construed in terms of the security and ability of the individual citizen to live with access to basic necessities of life such as maternal health care and exercise her democratic rights. While the poor are struggling to survive and women are dying due to avoidable maternal health causes, leaders are busy purchasing arms to suppress human rights and freedoms to ensure self-perpetuation in power. In my view, maintenance of

63 See <http://www.pubdocs.worldbank.org/en/748391470327541124/safegua> (accessed 8 February 2017).

64 See, Yasin Mugerwa, 'Uganda government takes shs. 1.7 trillion for jet fighters', *Daily Monitor* Newspaper, 26 March 2011, p. 1.

security becomes an empty slogan where women are dying due to the absence or denial of essential maternal health services.

Impact of the World Trade Organization

Neo-liberal policies of the World Trade Organization (WTO) have also led to agreements that have liberalized trade and investment with serious consequences for realization of MHRs in countries such as Uganda. These agreements – Trade Related Aspects of Intellectual Property Rights (TRIPS) and General Agreement on Trade and Services (GATS) – do not promote equity but unequal terms of trade. TRIPS has grave consequences for public health generally and maternal health in particular. TRIPS extends patent protection to drugs and pharmaceutical products. Current terms of world trade are more favourable to multilateral corporations and richer nations which host the world's pharmaceutical companies. These companies are so influential that they control trade in medicines by relying on patents protected by TRIPS.

TRIPS prescribes minimum standards that relate to the protection of intellectual property rights (IPRs) which include patents, trademarks, copyright, geographical indications and industrial designs. The minimum standards are binding on all the World Trade Organisation (WTO) members, including Uganda. The TRIPS Agreement protects 'process patents' which are concerned with the protection of methods of manufacturing, and 'product patents' which relate to the protection of pharmaceutical products.

Patent protection has been justified on grounds that it acts as an incentive for drug innovation, research and technological development. It is argued that patents enhance access to medicines through the development of new drugs (Corres, 2002: 35). It is further argued that patent holders need to recover the time – usually 10-15 years – and financial resources – averagely US\$ 500 million – invested in the research and development (R&D) of a drug (ibid). However, patents increase prices and limit access to medicines by placing them beyond the reach of poor people (Twinomugisha, 2015).

There is no doubt that intellectual property – especially patents – play a crucial role in the development of new medicines. However, patent monopolies have a deleterious impact on the price of medicines. Patentability creates a monopoly market in the product, which eliminates competition thereby maintaining high prices. With a monopoly situation, there is no competition to bring the prices of medicines down. Thus, patent protection hinders access to medicines in poor

countries such as Uganda. Patentability excludes the poor and all people with a weak purchasing power from accessing essential medicines and pharmaceutical products.

GATS covers many services including health. It liberalizes health services and opens them up to foreign competition. Foreign multinational companies, who have a lot of capital, control and influence financing of health care. GATS promotes international trade and privatization of health services leading to a less equitable health care system. Implementation of the agreement threatens universal provision of health and other related services by promoting privatization of these services and placing them beyond the reach of the poor. Opening up health markets will kill local initiatives and will skyrocket costs. These companies care more about profit maximization than the interests of the citizenry. Even locally, the trade in health services is in high gear: private persons, who are not even health professionals have and continue to set up for-profit health businesses. In utter disregard of patient rights, including personal liberty,⁶⁵ the private providers detain patients who are unable to pay! For example, International Hospital Kampala (IHK) recently detained a patient for failure to pay 19.5 million shillings.⁶⁶

Lack of Political Will

I pointed out above that the state has the primary responsibility to ensure realization of MHRs. However, the state must have the political will to discharge this responsibility. Political will plays a crucial role in agenda setting and the success and failure of any intervention. An issue becomes a political priority depending on the interests and viewpoint of political leaders. They are the ones to decide whether to increase the military or police budget or state house budget; buy more tear gas and police equipment to quell a demonstration and keep a leader in power or increase the health budget. Maternal health issues may be prioritized in policy documents, but is implementation prioritized? Political beliefs and values have a defining influence on political leaders' views of health related issues. If a leader believes in regime survival and preservation, he or she will prioritize resources towards that end to the detriment of health issues. In my view, the current state does not take maternal health issues seriously. Otherwise the \$ 740 million spent on military jets as illustrated above or the 600 million shillings or more spent on the President daily and the 773 billion on

65 Article 23(1) of the Constitution.

66 Anthony Wesaka, 'It is illegal for hospitals to detain patients over bills', *Daily Monitor* Newspaper, 22 November 2016.

the 2016 campaign⁶⁷ would have been invested in critical aspects of maternal health care such as skilled birth attendance and EmOC, which according to the World Bank can bring down the maternal mortality rate by 74 per cent.⁶⁸ As various commentators have observed, political will and focused leadership make innovative, cost-efficient interventions possible (Catford, 2006; WHO, 2010). Unfortunately, there is a lack of political will to marshal and direct the available physical, financial, human and other resources towards realization of MHRs.

Inequitable Gender Relations

Women who are battered by SAPs have another hurdle to contend with: inequitable gender relations. The concept of gender refers to the distinctive qualities of women and men that are constructed by society. According to FAO (1997), gender is ‘a central organized principle in societies, and often governs the processes of production and reproduction, consumption and distribution’. The concept of gender relations refers to ‘the ways in which a culture or society defines rights, responsibilities and the identities of men and women in relation to one another (Bravo-Baumann, 2000). It also refers to the relations between men and women that are socially, economically, politically and culturally constructed. Meena (1992: 102) defines gender as:

[s]ocially constructed and culturally variable roles that women and men play in their daily lives. It refers to a structural relationship of inequality between men and women as manifested in labour markets and in political structures, as well as in the household. It is reinforced by custom, law and specific development policies. Whereas sex is biological, gender is acquired and constructed by society.

Inequitable gender relations are a key challenge to the realization of women’s right to health and all its components such as MHRs (Twinomugisha, 2012). Inequality of these relations is perpetuated by the state and private actors, including the family and the community. Because of their poverty, which is largely attributed to the debilitating and disparate impact of SAPs, most women are continuously kept under time pressures trying to fend for themselves and their families. Because of the triple gender roles they play as producers, reproducers, care givers, agriculturalists and managers, these women have little or no time to

67 Yasin Mugerwa, ‘State house spends shs. 600 m everyday’ *Daily Monitor* Newspaper, 12 April 2013; Solomon Ariniatwe & Lelia Nalubega, ‘Museveni spent shs 773 billion on 2016 campaign-report’ *Daily Monitor* Newspaper, 10 July 2016; Lucy Nakyobe, ‘State house broke after spending on Museveni’s campaign’, *The Observer* Newspaper, 8 April 2016

68 <http://www.org/indicator/MS.MIL.XPND.ZS> (accessed 16 January 2017).

access and utilize maternal health services. Traditional division of labour assigns women the responsibility of domestic work and care of adults in addition to their child bearing and rearing roles. Men are often assigned productive work which generates income.

Some women work in agricultural plantations and fields where they are exposed to all sorts of pesticides, which may be harmful to their health and that of the foetus. Rural women, whether pregnant or not, use firewood to prepare food and are exposed to smoke, which may harm their lungs and foetus. Women who work in the agricultural and manufacturing sectors may not have protective gear and may be exposed to occupational accidents, hazards and injuries.⁶⁹ Women in the agricultural sector are required to perform labour intensive tasks such as weeding, transplanting and harvesting irrespective of whether a woman is pregnant or lactating. Perhaps, most of rural women's gender roles clearly fit in the description of the 'Woman of Africa' by Okotp'Bitek (1970: 41) as,

sweeper, smearing floors and walls, with cow dung and black soil,
cook, ayah, the baby on your back, vomiting, washer of dishes,
planting, weeding, harvesting, storekeeper, builder, runner of errands,
cart, lorry, donkey.

Because of their triple gender roles, women hardly get time to effectively utilise maternal health care services. This strenuous work has deleterious consequences for maternal health. While men's work is valued, either directly through paid remuneration or indirectly through status and power, women's work is often not recognised. Women's work is vital to the country's economy, but remains unrecognised and or unpaid. Perhaps, if women's work was recognised and paid, they would have money to purchase health care and other socio-economic services. Women may also lack economic decision making power. Whereas women contribute over 70 per cent of the labour force in agriculture, only 7 percent own land and through male relations (Asiimwe, 2014). Yet, land rights for women would increase productivity and equip them with resources for their welfare. In spite of this reality, policy implementers do not actively engage men as partners in the health and well-being of women.

Gender and cultural norms may also dictate early marriages for girls leading to early childbearing and high total fertility, both of which are linked to a higher risk

69 See, International Labour Organization (ILO) 'Safety and health in agriculture' http://www.ilo.org/wcmsp5/groups/---ed_protect---protrav/-safework/documents/publication/wcms_110193.pdf (accessed 15 March 2014).

of maternal mortality and morbidity. Women may also not access and utilize maternal health services due to violence orchestrated by their husbands or partners (Adjiawanou & LeGrand, 2014).

Using Criminal Abortion Laws to Undermine MHRs

I know that abortion is an emotive issue: there is a sharp divide between pro-life and pro-choice activists (Dworkin, 1993). Without allowing myself to be detained here by arguments of either side, one thing is clear: women are dying or suffering injury due to unsafe abortion. Women's MHRs are violated through unsafe abortion. WHO defines unsafe abortion as 'a procedure for terminating an unintended pregnancy performed by persons lacking the necessary skills, or in an environment that does not conform to minimal medical standards, or both' (WHO, 2014). Most of the unsafe abortions are carried out using unsafe means like drinking bleach, detergent, inserting sticks and coat hangers into a vagina which often result in severe complications like secondary infertility, chronic inflammation of the reproductive tract and hemorrhage (Cohen, 2009). Unsafe abortion is one of the main causes of maternal mortality and morbidity in the world (Kiggundu et al, 2008; WHO, 2011: 13). WHO (2014) estimates that deaths due to unsafe abortion make up to 14 per cent of all maternal deaths globally. Approximately 22 million unsafe abortions are conducted every year worldwide, resulting in the death of approximately 47,000 women (ibid). Disabilities from unsafe abortions affect an additional five million women every year (WHO, 2004: 1).

In Uganda, there are more than 300,000 abortions every year (Ministry of Health, 2015). About 26 percent of maternal deaths in the country result from unsafe abortion (Ministry of Health, 2015; Mbonye, 2000; Singh et al, 2005; Prada et al, 2005; Susheela, 2006). Apart from death, there are complications and disability from unsafe abortion, which include sepsis, peritonitis, haemorrhage, cervical trauma, uterine perforations, cervical injury, as well as chronic and permanent conditions (Abouzahr & E Ahman, 1998; Kinoti, 1995; Mbazira, 2011; WHO, 2012).

There is an undeniable fact: unsafe abortions are preventable. Access to contraceptives will prevent unwanted pregnancies. But what happens when a woman is already pregnant out of sexual violence for example, rape, defilement or incest? Should she carry an unwanted pregnancy against her will? What about the likely impact on her physical and mental health, which as illustrated above, are critical components of the right to health? Imagine the following scenarios:

Jane [not her real name], a 10 year old girl in primary school – class five – is defiled by her father. She becomes pregnant. She confides in you as her mother. You know a doctor who can safely terminate the pregnancy. What do you do? Do you let her carry the pregnancy or have it terminated?

Hellen [not real name] is taking an evening walk. She is raped by five men. She becomes pregnant. Should she carry the pregnancy to term?

Amina [not real name], an indigenous Ugandan woman married to an indigenous Ugandan man, has an affair with a *muzungu* (white man). She becomes pregnant. Would you advise her to carry the pregnancy at the risk of producing a coloured child whose paternity she is not going to gamble about?

The above and many other examples are what some women go through daily. Unfortunately, most of them may not access safe abortion services either because of the cost involved or due to fear of being prosecuted or the stigma associated with abortion. According to the WHO (2012: 19),

About 20-30% of unsafe abortion cause reproductive tract infections and 20-40% of these result in infection of the upper genital tract. One in four women who undergo unsafe abortion is likely to develop temporary or lifelong disability requiring medical care. For every woman seeking post-abortion care at a hospital, there are several who have had an unsafe abortion but who do not seek medical care, because they consider the complication as not serious, or because they may not have the required financial means, or because they fear abuse, ill-treatment or legal appraisal.

What is comforting is that it is now recognized that an induced abortion in sanitary conditions performed by qualified and skilled persons using correct techniques is ‘a very safe surgical procedure’ (WHO, 2012). Albeit access to safe legal abortion is a critical element of the continuum of maternal health care, the law in Uganda restricts termination of pregnancy. The Constitution provides that, ‘[n]o person has the right to terminate the life of an unborn child except as may be authorized by law,⁷⁰ and the Penal Code Act criminalizes attempting to procure an abortion,⁷¹ procuring a miscarriage,⁷² or knowingly supplying things

70 Constitution of the Republic of Uganda, 1995, Art 22(2).

71 Penal Code Act, Laws of Uganda, Cap 120, Sec 141.

72 Ibid, sec 142.

to procure an abortion or miscarriage.⁷³ Although section 224 of the Penal Code provides that surgical operations will not be deemed to amount to an offence ‘endangering life or health’ if they are performed on an unborn child in order to preserve the life of the mother, many health workers are either not aware of this provision or they fear prosecution (HRAPF, 2016). In any case, the section is restricted to surgical procedures and does not recognize effective medical forms of abortion such as mifepristone and misoprostol.

There is a direct correlation between restrictive abortion laws that criminalize women who seek abortions outside of the law, and high rates of unsafe abortion (Grime, 2006). Evidence shows that women who wish to terminate a pregnancy will do so regardless of its legal status and lawful availability, at the risk of going to prison, injuring themselves, or even death (Okonofua, 2008; Cohen, 2009; Amnesty International, 2014: 21). Almost all unsafe abortions – 97 percent – occur in developing countries with the most restrictive anti-abortion laws (Berer, 2004; Haddad & Nour, 2009). The median rate of unsafe abortions in the 82 countries with the most restrictive abortion laws is up to 23 out of 1000 women compared to only 2 out of 1000 in nations with liberal abortion laws (Grime et al, 2009). Countries with liberalized abortion laws have the fewest fatalities resulting from abortions (Cohen, 2009).

Many African states have, by ratifying the Women’s Protocol, recognized the need to safeguard women’s reproductive rights, including access to safe legal abortion. The Protocol enjoins states to,

protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.⁷⁴

Uganda ratified the Women’s Protocol with a reservation to the effect that this provision shall not apply to the Republic of Uganda unless permitted by domestic legislation. In my view, the reservation does not affect the application of the exception discussed above, namely, the need to preserve the mother’s life, physical and mental health and the possibility of developing future legislation removing the legislative barriers to abortion. Women who become pregnant as a result of crimes such as rape, defilement and incest are victims of sexual violence and may be further traumatised by health professionals, the police and

⁷³ Ibid, sec 143.

⁷⁴ Art 14(2)(c) of the Protocol. See also, African Commission, General Comment 2.

religious leaders. As Mavundla and Ngwena (2014: 62) have observed,

a woman who becomes pregnant due to an act of rape is the victim of a violent and morally reprehensive crime. Yet, the issue of not providing safe abortion to victims of rape must be understood as a form of violence against women for the reason that it puts their health and lives in serious danger.

The Committee on ESCR has also noted that the respect, protection and fulfilment of human rights require, amongst others, ‘the amendment of laws that criminalize medical procedures only needed by women, and punish women who undergo these procedures’.⁷⁵ The CEDAW Committee has also stated as follows:

Measures to eliminate discrimination against women are considered to be inappropriate if a health care system lacks services to prevent, detect, and treat illnesses specific to women. It is discriminatory for a state party to refuse to provide legally for the performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious objection, measures should be taken to ensure that women are referred to alternative health providers.⁷⁶

Although the high levels of unintended pregnancies may be attributed to the low use of modern contraceptives in the country (UBOS, 2012), criminalisation of abortion also has a significant contribution to make. Because of the restrictive legal provisions on abortion and the attendant sanctions, most health workers may be reluctant to assist women who are in need of abortion services. Criminalization of abortion has serious implications for realization of MHRs. In the first place, because of fear of arrest and prosecution, health workers may clandestinely perform abortion at exorbitant prices thereby making abortion services economically inaccessible for the majority of rural and urban poor women. In any case, because of criminalisation of abortion, information about the discreet services provided by health workers may not be available. Poor rural women, whose access to modern health services is limited by financial constraints and geographical distance, often resort to abortions performed by untrained and unskilled providers using unsafe instruments or may attempt to self-induce an abortion (Prada, 2005). In any case, as pointed out above, unsafe

75 Concluding Observations of the CESCR. E/C.12/1 Add. 101, para 23.

76 UN Committee on CEDAW, General Recommendation 24 (article 12 of the Convention [Women and Health], 20th Sess., para 11, A54/38/Rev.1, chap 1 (5 February, 1999).

abortion significantly contributes to maternal mortality and morbidity in Uganda. According to the WHO (2012: 19),

complications of unsafe abortion include haemorrhage, sepsis, peritonitis, and trauma to the cervix, vagina, uterus and abdominal organs. About 20-30% of unsafe abortion cause reproductive tract infections and 20-40% of these result in infection of the upper genital tract. One in four women who undergo unsafe abortion is likely to develop temporary or lifelong disability requiring medical care. For every woman seeking post-abortion care at a hospital, there are several who have had an unsafe abortion but who do not seek medical care, because they consider the complication as not serious, or because they may not have the required financial means, or because they fear abuse, ill-treatment or legal appraisal.

It should also be pointed out that abortion is not only a question of gender but also a class issue. In 2003, 68-75 per cent of rural poor women who had an abortion experienced complications, compared with 17 per cent of non-poor urban women who were handled by a doctor (Susheela, et al, 2006). In any case, most urban women may afford the cost of safe termination of pregnancy.

It is unfortunate that the law undermines the realization of MHRs by restricting an important aspect of women's human rights: the right of access to safe abortion services. The law is discriminatory in that it criminalises health services – access to abortion – that only women need. Such a law impairs women's right to reproductive choice – to make free and responsible decisions. In so doing, the state through law exercises a significant influence over a woman's bodily autonomy in general and over the construction of her sexuality in particular. A woman is compelled to be a mother, yet from a human rights perspective, motherhood should be a choice that is available to those who need it. Denying women the right of access to safe abortion makes them bear the hardship and blame for unwanted pregnancies, ignoring the fact that men bear the responsibility too, and that unwanted pregnancies may have resulted from unwanted intercourse such as rape, defilement and incest. In such a case, the law violates women's rights to health, bodily integrity and at times life itself.

Conclusion and Recommendations

MHRs are recognized in the Constitution and international and regional human rights instruments, which Uganda has ratified. Both the state and non-state actors have obligations to protect and uphold MHRs. Maternal health is a question of social justice: every mother should have equal access to MHRs irrespective of where she lives or what she does. Protecting the health of mothers during reproduction safeguards their future contribution to society and ensures the health and productivity of future generations. Realization of MHRs is hampered by neo-liberalism, which exalts market forces and private interests to the detriment of maternal health. Neo-liberal policies, which emphasize maximization of profits and their benefits, are antithetical to realization of MHRs of poor women, since they lack income to pay for maternal health commodities. Realization of MHRs is also hampered by inequitable gender relations and criminal abortion laws. There is also a lack of political will to judiciously and efficiently marshal and direct resources towards the realization of critical components of MHRs.

The realization of MHRs will remain elusive in Uganda unless the root causes of maternal mortality and morbidity are addressed. The problem is not simply poverty, which is a mere symptom of the problem, but the unbalanced concentration of capital in fewer hands and the unjust distribution of social wealth. Economic growth alone may not enhance maternal health. Economic growth must be combined with state action to ensure redistribution of resources and the direction of the benefits of economic growth to socio-economic projects for the public good such as maternal health. Most causes of maternal mortality are surmountable and the benefits of investing in maternal health far outweigh the costs. What is required is good politics that prioritizes investment in key issues of human development such as MHRs. With increased political will and prudent, judicious and efficient use of financial resources, maternal mortality and morbidity can be drastically reduced. Below, I advance some recommendations for the enhanced realization of MHRs.

Prioritize MHRs of the Poor

The neo-liberal approach to maternal health should be reversed. Government should prioritize investment in health systems, including meeting the Abuja Declaration target to invest 15 percent of the national budget in health. However, increasing the budget is not enough. The allocated money may be consumed in purchasing and maintenance of fuel guzzling vehicles, workshops, and travel allowances without seriously addressing critical maternal health needs. The available funds must be allocated in a cost effective and fair manner, paying particular attention to vulnerable groups such as rural and urban poor women. Thus, Parliament should, in scrutinizing the health budget, ensure that critical maternal health needs have been catered for. Civil Society Organizations (CSOs) should engage more directly in the debate about budgetary allocations to the health sector. They should also follow up with the Ministry of Health how the allocated money has been distributed among the competing maternal health needs.

The state has to play an active role in determining the direction of production, distribution, allocation and redistribution of resources. It is difficult to perform this role through the market mechanism. The state should provide for free, EmOC to all women who develop complications. Government must prioritize measures that promote universal access to high quality emergency obstetric services. It should ensure skilled attendance by devising strategies to train and retain skilled staff who are able to deliver the emergency care. In addition to a facility-based skilled attendance, a well-functioning health system with provision of equipment, drugs and other supplies is needed for the effective timely management of delivery complications, which may lead to maternal deaths. Midlevel staff should be upgraded through training to provide life saving obstetric surgery. Health workers with midwifery skills should be present at childbirth, backed by transport in case of emergency referral. Every Health Centre IV should have a fuelled ambulance with a full time driver; hydroelectricity or solar power or a stand by generator; a solar charged phone; and solar powered generator. The available scarce resources should be used to increase the proportion of deliveries with skilled birth attendance.

In order to adequately reduce maternal mortality and morbidity, it is essential to address poverty and the factors that cause it. Uganda should lobby other African governments so that they can reach a common position: to cancel or have the unsustainable external debt written off. Postponing or rescheduling the debt or debt relief, though helpful, is simply postponing the problem to the future. Any

further external borrowing should only be for priority areas, including health. It is also essential to develop sharpened normative guidelines that favour redistributive social justice at the production and consumption levels. The state needs a policy towards redistributive social justice, including ensuring equity and land rights for women. It should tax the privileged and rich and use the proceeds to fund social services such as maternal health care. Local capitalists should be promoted through support of domestic industry, including increased funding for agriculture, so that their increased revenue may be taxed.

Tackling Inequitable Gender Relations

A gender perspective should be incorporated in all policies, programmes and practices, and in all spheres of life including family and community life. Gender relations must become an integral part of all poverty related issues including maternal health care. Tackling inequitable gender relations involves adjusting entrenched and deeply embedded norms of behaviour and traditional beliefs about gender roles in society. Thus, it is no easy task. However, with some political will and determination some of these can be tackled through a number of measures which include, recognizing the economic value of women's domestic work because of its contribution to families, the community and the state. Domestic work should be calculated in official economic statistics. Marriage laws could incorporate provisions to the effect that a wife's contribution in form of domestic labour be valued as contribution to family property to which she is entitled to a share. The state can grant incentives such as tax relief to fathers who participate in domestic work. Local Council (LC) officials, especially women leaders can assist in identifying such men. Offering services where rural women work, for example, near the farm or garden is likely to increase the opportunity to receive maternal health care. It is also helpful to provide labour, energy and time saving devices that contribute to tackling rural poverty and deprivation. Unpaid care should be incorporated into the national public agenda. The burdens associated with performing gender roles can be reduced by redistributing responsibilities for care for example towards the state, community and men.

Public awareness and sensitization strategies by the Ministry of Health and CSOs should target both women and men. Men must be involved in education concerning sexuality, fertility, anatomy, contraception and other related health issues. Implementing gender strategies implies accepting that women's and men's lives are interlinked. Discussion of gender issues must include both women and men in order to increase the likelihood of a less traumatic transition towards gender equality. Not all men are villains: some are active partners in

the struggle to realize women's MHRs. The strategies should encourage couples to discuss contraceptive options and other reproductive health decisions. They should focus not only on attempting to change sexual behaviour or encouraging contraceptive use but changing existing gender relations. Efforts should be made to emphasize men's shared responsibility in bringing children into the world and this should be instilled in males at young ages. Emphasizing reproductive roles and responsibilities implies that men are obliged, in human rights terms, to carry out certain activities and can therefore be held accountable. Families and communities should be sensitized about the importance of women's health to the health of the community as a whole, and the dangers of early marriage and child bearing. It is unfortunate that the government has banned sexuality education in schools, which is an important arena of educating children about questions of sexual and reproductive health.⁷⁷

Legislative Interventions

The right to health should explicitly be provided for in the Bill of Rights of the Constitution in order to remove ambiguity about its justiciability. The Bill of Rights, especially under the article on women's rights, should also provide for the right of access to EmOC. Parliament should also enact a reproductive health law that gives prominence to the protection of MHRs, including spelling out the obligations of the state and non-state actors in the field of maternal health. The law should also provide for regulation of charges for maternal health services by private health providers.

There is also an urgent need to address unsafe abortion, which is one of the major contributors to the high rates of maternal mortality rates by reviewing the criminal laws on abortion. Lessons should be learnt from other African jurisdictions such as South Africa, Ethiopia, Zambia, Tunisia, Swaziland and Zimbabwe, which have liberalized their laws to ensure that women access safe legal abortion. This can be achieved in a number of ways. In the first instance, Parliament can pass a Termination of Pregnancy Act where abortion is a matter of choice for a pregnant woman especially within the first trimester. However, given the deeply entrenched religious and cultural norms, which are against abortion, the law should, in the short and medium terms remain restrictive but authorize medical abortion in cases of sexual assault, rape, incest, defilement and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or fetus. In other words, Uganda should

77 See, Chris Kiwawulo and Mary Karugaba, 'Government bans sexuality education' *Saturday Vision* Newspaper, 29 October 2016.

domesticate article 14(2)(c) of the Women's Protocol by removing the reservation in respect of this provision.

Liberalizing safe abortion is not enough. It should be accompanied by aggressive sensitization of law enforcement personnel, health workers and communities on the link between unsafe abortion and maternal mortality and morbidity and the need to enable women and girls access safe and legal abortion. Safe legal abortion services should be provided free of charge in all public health facilities. Health workers should also be trained on conducting safe legal abortion. A worker who may object to performing an abortion on grounds of conscience must refer the woman in the shortest time possible to the nearest alternative health worker who is willing to provide the service. However, he or she cannot refuse to provide emergency care where a woman's life is in danger. The Ministry of Health should also commence the sensitization of health workers and the public on the provisions on safe and legal abortion contained in the 2015 standards and guidelines on the reduction of maternal mortality and morbidity due to unsafe abortion.

Enforcing MHRs Through the Courts

The Constitution allows any person who claims that his or her right has been violated to seek redress from court, including compensation.⁷⁸ Thus, courts and other quasi-judicial bodies such as the Uganda Human Rights Commission, can be utilised to challenge violations of MHRs. Courts can play a significant role in the struggle to realise the right. Courts can clarify on the nature, scope and content of MHRs, thereby enriching the jurisprudence in the area. Litigation can be used to catalyse policy reform and give greater clarity and meaning to MHRs. By framing poverty issues such as access to maternal health services in the language of rights and constitutional obligations, the litigation process assists in placing issues on the agenda, both before the judge and the court of public opinion, especially through media reporting. Litigation is an important tool for demanding accountability from the state and non-state actors. It can be used to challenge inappropriate state action and address state inaction. Through litigation, the court may act as a voice for poor women in their struggle to realize MHRs.

The Constitution provides for the concept of public interest litigation (PIL), whereby 'any person or organization may bring an action against the violation

78 Art 50(1) of the Constitution.

of another person's or group's human rights'.⁷⁹ PIL seeks to precipitate social change through court action and as Scott and Deborah (2009) have observed, PIL

is a key strategy for protecting the rights and enlarging the power of subordinate groups, particularly when other channels of influence are unavailable. Groups hobbled by discrimination or collective action problems may turn to courts as allies in the struggle for social justice.

PIL is an important mechanism for enforcing human rights and recognises the vulnerability of disadvantaged persons or groups such as indigent women who, owing to their poverty, may not be in a position to file actions in their own names. Thus, PIL affords juridical space to previously ignored or excluded groups who lack formal access to power; they are able to enter into contested policy issues and participate in the broader social agenda (Yamin & Gloppen, 2001).

A person is not required to have a personal interest or injury before lodging an action alleging a violation of another person's or groups' human rights. Individuals or CSOs working for the public good can bring the violation or threatened violation of specific components of MHRs to the attention of the court. Thus, the state can be challenged in court to show what steps it has taken to realise MHRs. Lawyers engaged in PIL must be ready to confront objections from the state against the justiciability of socio-economic rights such as the right to health. It is worth noting that the state is likely to argue that judges are not particularly well equipped to deal with issues involving economic, social and other questions, which have budgetary implications. It should be emphasised to the court that both civil and political and socio-economic rights involve expenditure and thus have resource implications. The lawyers can cite examples of funding of elections, financial support to the judiciary, the construction of courts, and prisons. Drawing on judicial precedent from other jurisdictions, it should be impressed upon the judges that the Constitution mandates them to adjudicate all categories of rights without discrimination. Public interest lawyers can also rely on civil and political rights such as the right to life to argue the case for MHRs.

The Constitution is clear: judicial power 'is derived from the people and shall be exercised by the courts...in the name of the people'⁸⁰ in accordance with their 'values, norms and aspirations'.⁸¹ The courts have the legitimacy and competence

79 Art 50(2) of the Constitution.

80 Art 126(1) of the Constitution.

81 Ibid.

to adjudicate socio-economic rights. The poor, who are of course people, from whom judicial power is derived, also aspire to live a healthy and dignified life. The courts have to exercise their constitutionally guaranteed independence: to administer political and socio-economic justice without ‘control or direction of any person or authority’.⁸²

In order to succeed in its objectives, PIL should be buttressed by research, organisation and lobbying. CSOs and lawyers engaged in PIL must form important alliances with the major constituent groups and relevant stakeholders. There is need for public education and sensitisation of these groups and stakeholders, including legislators, judges, human rights commissioners, and health workers about the need to protect the MHRs and the implications of neglecting these rights (Twinomugisha, 2015).

Although litigation may not be a panacea to the challenges resulting from criminalisation of abortion, and ‘might even engender a backlash from patriarchal authorities and constituencies’ (Ngwena, 2014: 50), it sensitises civil society and raises ‘public consciousness about how national authorities deny human rights through failure to implement rights already guaranteed and, in the process foreground or reinforce transformative strategies’ (Ibid). Thus, public spirited CSOs and lawyers can for example challenge the constitutionality of the restrictive abortion laws on grounds that they violate fundamental human rights such as equality and non-discrimination, freedom from cruel, inhuman and degrading treatment, the right to privacy and above all the right to life.

Towards a Democratically Reconstituted State

In my view, in the long run, for actual and meaningful realization of MHRs to occur, there must be a peaceful democratic struggle aimed at changing the current regime. However, one major drawback is that social consciousness is lacking in the country. Millions of the population, including poor women who lack access to MHRs, are peasants who live in rural areas, but seem not to realize the need for change. There is an urgent need to make them aware of their MHRs, including demanding accountability from the state and non-state actors.

There is need to build consciousness among the masses so that they are able to engage in a struggle for emancipation. This struggle should be led by the working class, including rural and urban poor women and men. The struggle should lead to a democratically reconstituted liberal pro-people socialist state that will

82 Art 128(2) of the Constitution.

promote an equitable distribution of resources and ensure that maternal health issues are prioritized in design and implementation. However, as Ake (1996) cautions, the working class must be prepared to face the regime, which may use coercive state machinery, to defend itself against any attempts to change the *status quo* and lose their privileges.

Ladies and gentlemen, in your distinguished capacities, I profoundly thank you for sparing time from your busy schedules and coming to listen to my humble contribution to the struggle to realise MHRs in the country. I humbly request you that from henceforth, I should be called a *Professor of Health Law*. Thank you very much.

REFERENCES

- Abouzahr, C & Ahman, E (1998) 'Unsafe Abortion and Ectopic Pregnancy' in CTL Murray & D Lopez (eds) *Health Dimensions of Sex and Reproduction: The Global Burden of Sexually Transmitted Diseases, Maternal Conditions, Perinatal Disorders and Congenital Anomalies*, Boston: Harvard School of Public Health, pp. 266-296.
- Adjiawanou, V & LeGrand, T (2014) 'Gender Equality and the Use of Maternal Healthcare Services in Rural Sub-Saharan Africa's Health Place', <http://www.ncbi.nlm.nih.gov/pubmed/24994096> (accessed 25 January 2017).
- Ake, Claude (1996) *Social Science as Imperialism: The Theory of Political Development*. Ibadan: Ibadan University Press.
- Akin, JS et al (1987) *Financing Health Services: An Agenda for Reform*. Washington DC: World Bank.
- Amin, S (1990) *Delinking: Towards a Polycentric World*. London: Zed.
- Aoife, N (2014) 'Holding Non-state Actors to Account for Constitutional Economic and Social Rights Violations: Experiences and Lessons from South Africa and Ireland', 12 *International J Constitutional Law* 1, 61-93.
- Asiimwe, J (2014) 'Making Women's Land Rights into a Reality in Uganda: Advocacy for Co-ownership by Spouses' 4 *Yale Human Rights and Development Journal* 1.
- Bela, C et al (2014) 'From Concept to Measurement: Operationalizing WHO's Definition of Unsafe Abortion', available at <http://www.who.int/bulletin/volumes/92/3/14-136333/en/> (accessed 27 January 2017).
- Berer, M (2004) 'National Laws and Unsafe abortion: The Parameter of Change' 12 *Reproductive Health Matters* 1.
- Bravo-Baumann, H (2000) Capitalization of Experiences on the Contribution of Livestock Projects to Gender Issues. Working Document, Bern: Swiss Agency for Development and Cooperation.
- Cabel, P & Harris, P (1982-83) 'Building Power and Breaking Images: Critical Legal Theory and The Practice of Law' *N.Y. REV.L& SOC. CHANGE* 8.
- Catford, J (2006) 'Creating Political Will: Moving From the Science to the Art of Health Promotion', *Health Promot Int.* 21.
- CEHURD (2016) *Facing Uganda's Laws on Abortion: Experiences from Women and Service Providers*. Kampala: CEHURD.
- Chambers, JB (2011) 'Legal Positivism; An Analysis', Undergraduate Honors Theses, Paper 79, available at <http://www.digitalcommons.usu.edu/cgi/viewcontent.cgi?article=108> (accessed 2 February 2017).
- Cohen, S (2009) 'Facts and Consequences: Legality, Incidence and Safety of Abortion Worldwide' 12 *Guttmacher Policy Review* 4.

Coburn, D (2000) 'Income Inequality, Social Cohesion and the Health Status of Populations: The Role of Neo-Liberalism' 51 *Social Science and Medicine* 135-56.

————— (2001) 'Health, Health Care and Neo-liberalism', in D. Coburn (ed) *Unhealthy Times: The Political Economy of Health and Care in Canada*. Toronto: Oxford University Press.

————— (2004) 'Beyond the Income Inequality Hypothesis: Class, Neo-liberalism, and Health Inequalities' 58 *Soc. Sci. Med* 1.

————— (2010) 'Health and Health Care: A Political Economy Perspective', in Bryant, T *et al* (eds) *Staying Alive: Critical Perspectives and Health Care*, 2nd ed. Toronto: Canadian Scholars Press.

————— (2003) 'Globalisation, Neo-liberalism and Health', in Sandbrook, R (ed) *Civilizing Globalization*. Albany: State University of New York Press, pp. 27-38.

————— (2014) 'Neoliberalism and Health', in The Wiley Blackwell Encyclopedia of Behaviour and Society, <http://www.onlinelibrary.wiley.com/doi/10.1002/9781118410868.wbehisbis149/abstract> (accessed 30 January 2017).

Cook, RJ (1994) 'State Accountability under the Convention on the Elimination of All Forms of Discrimination Against Women', in Cook, RJ (ed.) *Human Rights of Women, National and International Perspectives*. Philadelphia: University of Pennsylvania Press.

Cook, R *et al* (2014) *Abortion Law in Transnational Perspective: Cases and Controversies*. Philadelphia: University of Pennsylvania Press.

Correa, C (2002) *Intellectual Property Rights, the WTO and Developing Countries*. London: Zed Books.

Delphine Hu, *et al* (2013) 'The costs, benefits, and cost-effectiveness of interventions to reduce maternal morbidity and mortality in Mexico', available at <http://www.journals.plos.org/plosone/article?id=10.1371/journal.pone.0000750> (accessed 12 December 2016).

Dworkin, R (1992) *Taking Rights Seriously*. Cambridge: Harvard University Press.

————— (1993) *Life's Dominion: An Argument about Abortion, Euthanasia and Individual Freedom*. London: Harper Collins.

FAO (1997) 'Gender: The Key to Sustainability and Food Security', available at <http://www.fao.org/sd> (accessed 30 January 2017).

Fathalla, MF (1988) 'Promotion of Research in Human Reproduction: Global Needs and Perspectives' *Human Reproduction* 3.

Frank, AG (1989) *Capitalism and Underdevelopment in Latin America*. Harmondsworth: Penguin Books.

Freedman, LP *et al* (2005) 'Transforming Health Systems to Improve the Lives of Women and Children' *Lancet* 365.

Golder, B (2014) 'Beyond Redemption? Problematizing the Critique of Human Rights in Contemporary International Legal Thought', 2 *Lond. Rev. Int. Law* 1.

Gordon, A (1986) *Transforming Capitalism and Patriarchy: Gender and Development in Africa*. London: Lyne Renne Publishers, Inc.

Susheela, S et al (2006) *Unintended Pregnancy and Induced Abortion in Uganda: Causes and Consequences*. New York: Guttmacher Institute.

Guttmacher Institute 'Fact sheet: Abortion in Uganda' <http://www.guttmacher.org/pubs/FB-Abor> (accessed 17 November 2016).

Haddad, LB & Nour, NM (2009) 'Unsafe abortion: Unnecessary maternal mortality' 2 *Review of Obstetric Gynecology* 2.

Hannum, H (1998) 'The UDHR in National and International Law'3 *Health and Human Rights* 2.

Harvey, P (2002) 'Human Rights and Economics Discourse: Taking Economic and Social Rights Seriously'1 *COLUM.HUM.RTS & HUM.WELFARE* 3.

Hellinger, S et al (1988) *Aid for Just Development*. Boulder: Lynne Rienner.

Hills, J (1994) 'Dependency Theory and Its Relevance Today: International Institutions in Telecommunications and Structural Power' *REV. INT'L. STUDIES* 20.

Human Rights Awareness and Promotion Forum (HRAPF) (2016) *The Enforcement of Criminal Abortion Laws in Uganda and its Impact on the Rights of Women and Health Workers*. Kampala: HRAPF.

Hunt, A 'Marxist Theory of Law', in Dennis Patterson, *A Companion to Philosophy of Law and Legal Theory*, available at <http://www.blackwellreference.com/public/tocnode?id=g978063121329125> (accessed 11 January 2017).

Hyden, G (1994) 'Changing Ideological and Theoretical Perspectives on Development', in Himmelstrand, U et al (eds), *African Perspectives on Development*. Kampala: Fountain Publishers.

Jochwick, C (1997) *Unleashing Human Rights to Address Global Poverty*. Ecuador: Center for Economic and Social Rights.

Jjuuko, FW (1995) 'The State, Democracy and Constitutionalism in Africa' *E. AFR J. PEACE & HUM RTS* 2.

Kanji, N & Manji, F (1991) 'From Development to Sustained Crisis: Structural Adjustment, Equity and Health' *Social Science and Medicine* 33, no.9.

Kinoti, SN et al (1995) *Monograph on Complications of Unsafe Abortions in Africa*. Baltimore: Johns Hopkins Program for International Education in Reproductive Health.

Kelsen, H (1967) *Pure Theory of Law*. Berkeley/Los Angeles: University of California Press.

Kiggundu, C (2008) 'Uganda: Abortion Situational Analysis Report', available at <http://www.figo.org/sites/default/files/UGANDA-situational-analysis%20with%20authors.doc> (accessed 20 October 2016).

Langlois, A (2012) 'Human Rights in Crisis? A Critique of Polemic Against Polemical Critics'

Journal of Human Rights 558.

Luther, M (1962) 'The Estate of Marriage', in *The Christian in Society* 46, quoted in Maine, D et al (1995) 'Risks and Rights: The Uses of Reproductive Health Data' *REPRODUCTIVE HEALTH MATTERS* 6.

McNeir Jr, DG (2014) 'Rwanda's Health Care Success Story' *New York Times*, available at <http://www.nytimes.com/2013/02/05/science/rwanda-health-care-success-story.html> (accessed 4 May 2015).

Marc, B (1989) 'Privatizing the delivery of social welfare services: An idea to be taken seriously' *Privatization and the Welfare State* 179.

Marks, S (2013) 'Four Human Rights Myths', in D. Kinley et al (eds) *Human Rights: Old Problems, New Possibilities*. London: Edward Elgar Publishing.

Marx Karl (1848) *Manifesto of the Communist Party*. Beijing: Foreign Language Press.

Maurice, C (1979) *Dialectical Materialism: An Introduction*. London: Lawrence & Wishart Ltd.

Mbazira, C (2011) 'In Legal and Human Rights Lens: Unsafe Abortion and the Law in Uganda' Kampala: FIDA-Uganda.

Mbonye, AK (2000) 'Abortion in Uganda: Magnitude and Implications' 4 *African Journal of Reproductive Health* 104.

Melissa, T et al (2004) 'Neo-liberal Economic Practices and Population Health: A Cross-National Analysis' *Health Economics, Policy and Law* 1.

Meena, R (ed) (1992) *Gender in Southern Africa: Conceptual and Theoretical Issues*. Harare: SAPES Books.

Ministry of Health (2010a) *Health Sector Strategic Plan, 2010/11-2014*. Kampala: Ministry of Health.

————— (2010b) *Guidelines on Maternal Health in Uganda*. Kampala: Ministry of Health.

————— (2012) *The National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights*. Kampala: Ministry of Health.

————— (2015a) *Reducing maternal morbidity and mortality from unsafe abortion: Standards and guidelines*. Kampala: Ministry of Health.

————— (2015b) *Human Resources for Health: Bi-Annual Report October 2014-March 2015*. Kampala: Ministry of Health.

MOFPED (2010) *National Development Plan 2010/11-2014/15*. Kampala: MOFPED.

Mkandawire, T 'Thinking About Developmental States in Africa' http://www.archive.unu.edu/hq/academic/Pg_area4/mkandawire.htm (accessed 12 December 2016).

Moon, R (1988) 'Discrimination and its Justification: Coping With Equality Rights under the Charter' *Osgood H.L.J* 26.

Mutua, M (1997) 'Reformulating the Discourse of the Human Rights Movement' 3 *E. AFR J. PEACE & HUM RTS* 2.

Nabudere, DW (1990) *The IMF-World Bank's Stabilization and Structural Adjustment Policies and the Uganda Economy*. Leiden: Africa Studies Centre.

Navarro, V (2007) 'What is the National Health Policy?' 37 *International Journal of Health Services* 1.

Ngwena, CG (2010) 'Inscribing Abortion as a Human Right: Significance of the Protocol on the Rights of Women in Africa' 32 *Human Rights Quarterly* 783.

————— (2014) *Using Human Rights to Realize Access to Safe, Legal Abortion in Uganda*. Kampala: CEHURD.

Odim, JC (1991) 'Common Themes, Different Contexts: Third World Women and Feminism', in Chandra, T.M *et al*, *Third World Women and the Politics of Feminism*. Bloomington: Indiana University Press.

Okeyo, A (1981) 'Reflections on Development Myths' *Africa Report* (March-April).

Olowu, D (1994) 'The Nature and Character of the African State'. Paper Presented for AAPAM 15th Roundtable at Bajul, Gambia, available at <http://www.unpan1.un.org/intradoc/groups/public/documents/aapm/unpan026543.pdf> (accessed 10 December 2016).

Okotp'Bitek (1970) *Song of Ocol*. Nairobi: East African Publishing House.

Osita-Eze, C (1979) 'Right to Health as a Human Right in Africa', in Rene-Jean, D *Le Droit a la Sante en taut que Droit de L'homene*. The Nether-lands: Sithoff and Noordhoff.

Pound, R (1942) *Social Control Through Law*. New Haven: Yale University Press.

————— (1954) *Philosophy of Law*. New Haven: Yale University Press.

Prada, E *et al* (2005) *Abortion and Postabortion Care in Uganda: A Report From Health Care Professionals and Health Facilities*. New York: The Guttmacher Institute.

————— (2016) 'Incidence of induced abortion' in Uganda, 2013: New estimates since 2003' 11 *PLOS One* 11.

Republic of Uganda (2010) *National Development Plan*, available at <http://www.opm.go.ug/assets/media/resources/30/NationalDevelopmentPlan201:11-2014:15.pdf> (accessed 3 December 2016).

————— (2013) *Uganda Vision 2040*. Kampala: National Planning Authority.

————— (2015) *Report on Public Debt (Domestic and External Loans), Guarantees, other Financial Liabilities and Grants for 2014/15*. Kampala: Parliament of Uganda.

Samuel, P (1979) *The Rational Peasant*. Berkeley: University of California Press.

Scott, LC & Deborah, LR (2009) 'Public interest litigation: Insights from theory and practice' *Fordham Urban Law Journal* 606.

Shivji, GI (2001) 'Ideology and Double-Talk: The Age of the Development Practitioners'. A Keynote Address at the International Conference to Celebrate the Life of Adulrahman Mohamed Babu, Dar-es-Salaam, September 2001.

————— (1989) *The Concept of Human Rights in Africa*, London: Codesria Book Series.

Singh, S et al (2005) 'The Incidence of abortion in Uganda' 31 *International Family Planning Perspectives* 183.

Stamp, P (1989) *Technology, Gender and Power in Africa*. Ottawa: International Development Research Centre.

Stiglitz, JE (2002) *Globalization and Its Discontents*. New York: W.W. Norton.

Tamale, S (2001) 'Between a Rock and a Hard Place: Women's Self Mobilization to Overcome Poverty in Uganda', in Rowbotham, S & Likongle, S (eds.) *Women Resist Globalization: Mobilizing for Livelihood and Rights*. London/New York: Zed Books.

————— (1999) *When Hens Begin to Crow: Gender and Parliamentary Politics in Uganda*. Kampala: Fountain Publishers Ltd.

Taylor, AL (1992) 'Making the World Health Organization Work: A Legal Framework for Universal Access to the Conditions for Health' *American Journal of Law and Medicine* 18.

Thaddeus, S & Maine, D (1994) 'Too Far to Walk: Maternal Mortality in Context', 38 *Soc. Sci. Med.* 8.

Thomas, P (2010) *Politics as Usual: What Lies Behind the Pro-Poor Rhetoric*. Cambridge: Polity Press.

Tomasevski, K (1985) 'Women', in Eide, A et al (eds) *Economic, Social and Cultural Rights*. Boston/London: Martin Nijhoff Publishers.

Twinomugisha, BK (2004) 'Protection of Rural Poor Women's Right of Access to Maternal Health Care in Uganda: The Case of Kashambya Sub-County, Kabale District', Unpublished Doctor of Laws (LL.D) Thesis, Makerere University.

————— (2007) 'Do The Rights of Poor Women Really Matter? Globalization and the Protection of Reproductive Health rights of Women in Uganda' 13 *East African Journal of Peace and Human Rights* 1.

————— (2008) 'A Critique of Uganda's PEAP', in Kahabele, M et al (eds) (2008) *The State, Democracy and Poverty Eradication in Africa*. Johannesburg: Global Print.

————— (2012) 'Beyond the Law: What Role Can the Gender Perspective Play in the Protection of the Right to Health?', in Viljoen, F (ed) *Beyond the Law: Multidisciplinary Perspectives on Human Rights*. Pretoria: Pretoria University Law Press.

————— (2015) *Fundamentals of Health Law in Uganda*. Pretoria: Pretoria University Law Press.

UBOS (2012) *Uganda Demographic and Health Survey 2011*. Kampala: UBOS.

————— (2016) *Uganda Demographic and Health Survey 2016*. Kampala: UBOS.

Uganda Consortium on Corporate Accountability (UCCA) (2016) *The State of Corporate Accountability in Uganda*. Kampala: UCCA.

Vlassof, C (1994) 'Gender Inequalities in Health in the Third World: Uncharted Ground', *Social Science and Medicine* 39, no.9.

WHO (1948) *Constitution of the World Health Organization*. Geneva: WHO.

————— (2010) *Maternal health: Investing in the Lifeline of Healthy Societies and Economies* (2010), available at http://www.who.int/pmnch/topics/material/app_maternal_health-english.pdf (accessed 4 November 2016).

————— (2004) *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2000*. Geneva: WHO.

————— (2012) *Safe abortion: Technical and Policy Guidance for Health Systems*. Geneva: WHO.

————— (2013) *Trends in Maternal Mortality: 1990-2013*. Geneva: WHO.

World Bank (2013) *Military Expenditure (% of Central Government Expenditure)*, available at <http://data.worldbank.org/indicator/MS.MIL.XPND.ZS> (accessed 2 February 2017).

————— (2016) *Uganda Poverty Assessment, 2016: Fact Sheet*, available at <http://www.worldbank.org/en/country/uganda/brief/uganda> (accessed 24 January 2017).

Wusnsh, JS & Olowu, D (eds) (1990) *The Failure of the Centralized African State: Institution and Self-Governance in Africa*. Boulder Colorado: West View Press.

Yamin, AE & Gloppen, S (eds) (2001) *Litigating Health Rights: Can Courts Bring Justice to Health?* Harvard: Harvard University Press.



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