CEHURD
social justice in health

LiRA Litigating
Reproductive Justice in Africa

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THE JOURNEY OF LITIGATING REPRODUCTIVE JUSTICE CASES; LESSONS FROM UGANDA

2023

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LIST OF ACRONYMS AND ABBREVIATIONS

ACHPR	African Charter on Human and Peoples' Rights
ACRWC	African Charter on the Rights and Welfare of the Child
ADR	Alternative Dispute Resolution
AG	Attorney General
AIDS	Acquired Immune Deficiency Syndrome
CA	Constituent Assembly
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CEFROHT	Centre for Food and Adequate Living Rights
CEHURD	Center for Health, Human Rights and Development
CRC	Convention on the Rights of the Child
CRR	Center for Reproductive Rights
CSE	Comprehensive Sexuality Education
CSMMUA	Coalition to Stop Maternal Mortality due to Unsafe Abortion
CSOs	Civil Society Organizations
DMS	Director of Medical Services
EACJ	East African Court of Justice
FY	Financial Year
HIV	Human Immunodeficiency Virus
HRAPF	Human Rights Awareness and Promotion Forum
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
IVF	In Vitro Fertilization
KOGS	Kenya Obstetrical Gynecological Society

LGBT	Lesbian, Gay, Bisexual, and Transgender
LSN	Legal Support Network
MMR	Maternal Mortality Ratio
MSWNH	Mulago Specialized Women and Neonatal Hospital
RJ	Reproductive Justice
SL	Strategic Litigation
SOPS	Standard Operating Procedures
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually Transmitted Infections
STDs	Sexually Transmitted Diseases
UDHR	Universal Declaration of Human Rights
UNHCO	Uganda National Health Consumers Organization
UDHS	Uganda Demographic and Health Survey
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WPI	Women's Probono Initiative

1. INTRODUCTION

The Center for Health, Human Rights and Development (CEHURD) has since its inception, engaged courts and quasi-judicial bodies as an arena for realization of reproductive justice (RJ) in Uganda. CEHURD has been a trailblazer in utilizing litigation as a strategy to enhance the protection of the right to health generally and Sexual and Reproductive Health and Rights (SRHR) in particular. CEHURD has challenged some reproductive injustices in Ugandan courts through Strategic Litigation (SL), also known as impact litigation, which involves instituting a case or action before a court of law with a view of bringing about certain social, political or juridical changes. Unlike 'regular' litigation, which focuses on the interests of a particular client and winning a case with the attendant legal costs, SL moves beyond individual client interests and focuses on creating an impact for a larger group of people. SL largely focuses on creating change beyond winning the case. As Open Society Foundations observed, SL 'is litigation with an intended impact beyond a particular case to influence broader change at the level of law, policy, practice, or social discourse'[1]. SL may also be aimed at 'enforcement and practice or raising the visibility of an issue and changing attitudes'[2]. Although CEHURD has actively pursued SL, it has not sufficiently documented its litigation journey on RJ. Against this backdrop, CEHURD engaged a consultant to undertake a critical analysis of selected RJ related cases and develop a knowledge product on the litigation journey.

2. METHODOLOGY

The consultant employed desk review of court cases on RJ handled by CEHURD and other purposely selected organizations, namely, Human Rights Awareness and Promotion Forum (HRAPF); Women's Probono Initiative; and Center for Reproductive Rights (CRR). Relevant materials published in reports and similar documents available in libraries and websites were also considered. The consultant carried out interviews with purposively selected individuals in CEHURD and other organizations that have been involved in SL of RJ related cases. The purpose of involving other organizations in the discussion was to decipher lessons that CEHURD may learn from their experience in litigating RJ. The discussion was guided by a number of questions, including:

- What problem prompted the filing of the case?
- What were the goals of the litigation?
- How adequate were the resources required for the case?
- What kind of partnerships did you have with other organizations in conceptualizing and or handling the case?
- What advocacy efforts were employed?
- What has been the impact of the litigation, regardless of the outcome?
- What challenges were faced during the litigation process?

[1]. Open Society Foundations, Advancing Public Health through Strategic Litigation: Lessons from Five Countries, p. 4.
[2]. Ibid.

3. UNDERSTANDING REPRODUCTIVE JUSTICE

RJ is not a new concept as such. It builds on the pronouncements at the 1994 International Conference on Population and Development (ICPD). The ICPD marked a paradigm shift from a focus on population and fertility control to placing women's rights at the heart of population and development policies and underlined women's rights to Sexual and Reproductive Health (SRH)[3]. The Reproductive Health and Rights approach, which was adopted at the ICPD, focused on women's health and well-being and informed later discourses on RJ.

The ICPD elucidated on two major concepts in the field of women's human rights: reproductive health and reproductive rights. Reproductive rights are recognized at the international, regional and national levels. Reproductive rights include, rights of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children and to have the information and means to do so, and the right to the highest attainable standard of SRH. Reproductive rights also include the right of couples and individuals to control their fertility and make decisions concerning reproduction free from discrimination, coercion and violence. These rights were underlined at the ICPD and reaffirmed at the 1995 United Nations Conference held in Beijing and are contained in international instruments, including the Universal Declaration of Human Rights (UDHR), International Covenant on Civil and Political Rights (ICCPR), International Covenant on Economic, Social and Cultural Rights (ICESCR), Convention on the Elimination of all Forms of Discrimination against Women, and Convention on the Rights of the Child (CRC). Reproductive rights are also provided for in regional instruments such as the African Charter on Human and Peoples' Rights (ACHPR), the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) and the African Charter on the Rights and Welfare of the Child and national legal frameworks and consensus documents.

RJ moves beyond reproductive rights and incorporates the economic, political, social, spiritual, cultural and health factors that impact on women's reproductive choices and decision-making ability. According to SisterSong, RJ 'is the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities'[4]. Thus, there are three core values of RJ namely, the right to have a child; the right not to have a child; and the right to parent a child or children in safe and healthy environments.

RJ is rooted in the international human rights frameworks and tackles experiences of reproduction through a combination of reproductive rights and social justice. RJ transcends the pro-choice and pro-life debates and addresses 'reproductive issues across the lifespan, including pre-and-post birth healthcare, the availability of sexual education, contraceptives, and reproductive technologies and affordable childcare'. [5]RJ calls for the broadening of the reproductive rights framework to include the impact of social relations and socio-economic conditions that affect women.

[3] BK Twinomugisha 'Judicial Evolution of Sexual and Reproductive Health Rights', in M Mulumba et al (2023) *A Walk through the CEHURD Garden: Situating Ourselves in the SRHR Movement in Uganda.* Kampala: Fountain Publishers.
[4] SisterSong, 'Reproductive justice' https://www.sistersong.net.
[5] R. Rebouche 'Reproducing rights: The intersection of reproductive justice and human rights' (2017) 7 *UCIRVINE LAW REVIEW*, pp. 579-609.

[6]Ross and Solinger correctly observe that 'reproductive justice is the application of intersectionality to reproductive politics in order to achieve human rights'[7].

4. LITIGATING REPRODUCTIVE JUSTICE THROUGH THE COURTS

4.1 Challenging Violations of Maternal and Child Health Rights

4.1.1 Center for Health, Human Rights and Development (CEHURD), Prof Ben Twinomugisha, Rhoda Kukiriza & Inziku Valente v. Attorney General (Constitutional Petition No. 16 of 2011)

The Context

One of the major components of RJ is the right to have a child whose realization depends largely on the level of access to maternal health services. The enjoyment of maternal health rights is thus critical to the achievement of RJ. Maternal health rights, which are cardinal components of the right to health, are provided for in various international and regional human rights instruments, which Uganda has subscribed to.

The ICESCR entitles every person to the right to the highest attainable standard of physical and mental health[8] and State Parties are called upon to take steps necessary for 'the reduction of the stillbirth rate and infant mortality and the healthy development of the child'[9]. In General Comment No. 14 on the Right to the Highest Standard of Health, States are obliged to ensure availability, accessibility, acceptability and quality of maternal health care goods and services.[10] CEDAW obliges States to ensure women's access to health care, including those related to family planning services[11]. States have an obligation 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'.[12] The Convention on the Rights of the Child recognizes 'the right of the child to the enjoyment of the highest attainable standard of health'[13] and enjoins States to take appropriate measures, among others, to diminish infant and child mortality.[14] Sustainable development Goal (SDG) Target 3.1 requires states, including Uganda, to reduce the maternal mortality ratio to less than 70 per 100,000 live births by 2030.

The Maputo Protocol obliges States to ensure respect and promotion of women's right to health, including SRH.[15] States are obliged to 'establish and strengthen existing prenatal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-

6. L. Ross, 'Understanding reproductive justice: Transforming the pro-choice movement' https://www.law.berkeley.edu/php-programs/centers/crrj/zotero/loadfile.php?entity_key=6NK5BUG9 (accessed 28 August 2023).
7. Ross, L & Solinger, R (2017) *Reproductive Justice: An Introduction.* Vol. 1. University of California Press.
8. Article 12(1).
9. Article 12(2)(a).
10. Paragraphs 14; 44(a).
11. Articles 12(1); 14(2)(b
12. Article 12(2).
13. Article 14(1).
14. Article 14(2)(a)).
15. Article 14(1)).

feeding'[16]. The African Charter on the Rights and Welfare of the Child obliges States to take measures to, among others, reduce infant and child mortality rates; provision of medical assistance and health care to all children; and ensure appropriate health care for expectant and nursing mothers.[17]

Uganda, as a signatory to the above instruments, has obligations to respect, protect and fulfill maternal health rights. Although the Constitution of the Republic of Uganda does not have an explicit provision on the right to health, including maternal health rights, in the Bill of Rights,[18] it obliges the State to ensure that all Ugandans enjoy the right of access to health services (Objective XIV). The state is enjoined to 'take all practical measures to ensure provision of basic medical services to the population'[19]. According to the Constitution, the State 'shall protect women and their rights, taking into account their unique status and natural maternal functions in society'[20].

In spite of these legal provisions, the maternal health situation in Uganda is worrying. Many women die from pregnancy and child-birth related complications. Those who survive may lose their babies. Though the maternal mortality ratio (MMR)[21] has reduced from 438 deaths per 100,000 live births[22], (at the time of filing the Petition in 2011), to 336 maternal deaths per 100,000 live births (UBOS, 2016), and to the current figure of 189 maternal deaths per 100,000 live births (UBOS, 2022), it is still unacceptably high. In any case, the pregnancy-related mortality ratio (PRMR)[23] is 228 deaths per 100,000 live births (UBOS, 2022). There is a lack of or limited supply of maternal health care goods and services such as mama kits and blood in most public health facilities in the country; low funding for health generally and maternal health care in particular; frequent stock outs of essential maternal health commodities; lack of emergency obstetric care; non-supervision of public health facilities; and unethical behaviour of health workers[24]. In circumstances like these, many women lose their lives while others may suffer morbidities such as the dreaded obstetric fistula. Against this backdrop and given the maternal health situation in the country and the ambivalence surrounding the justiciability of the right to health, CEHURD decided to file Constitutional Petition No. 16 of 2011 with a view of holding the government accountable and determining the place of this in our jurisprudence.

Litigation

In this ground breaking case, the petitioners petitioned the Constitutional Court seeking declarations to the effect that the non-provision of essential maternal health commodities in public health facilities and the unethical conduct and behaviour of health workers towards expectant mothers are inconsistent with the Constitution and a violation of the right to health and other related rights namely, women's human rights, the right to life, and freedom from torture, cruel, inhuman and

16. Article 14(2)(b)).
17. Article 14(2)(a), (b), and (e).
18. Chapter Four of the Constitution.
19. Objective XX
20. Article 33(3).
21. The MMR refers to the number of women who die from pregnancy-related causes while pregnant or within 42 days of pregnancy termination per 100,000 live births.
22. UBOS (2011) Uganda Demographic and Health Survey 2011. Kampala: UBOS.
23. The PRMR refers to the number of pregnancy related deaths per 100,000 live births.
24. BK Twinomugisha (2017) Maternal Health Rights, Politics, and the Law. Professorial Inaugural Lecture, Makerere University.

degrading treatment.

The Attorney General (AG) raised a preliminary objection that the matters before court raised a political question. According to the AG, the petition required the court to make a judicial decision involving and affecting political questions. That in doing so, the court would in effect be interfering with the political discretion of other branches, namely, the executive and the legislature. The AG further contended that in order to determine the issues in the petition, the court had to call for a review of all the policies of the entire health sector and make findings on them, yet implementation of these policies is the sole preserve of the executive and the legislature. The AG prayed that the petition should be dismissed because the questions that informed it are not justiciable, that is, they are not capable of being decided by court. In reply, counsel for the petitioners argued that the preliminary objection was misconceived as the question to be determined was whether the acts and omissions are in contravention of the Constitution and not the determination of a political question.

The court agreed with the AG and dismissed the petition. The court stressed the importance of separation of powers in the implementation of policies and stated as follows:

> Much as it may be true that the government has not allocated enough resources to the health sector and in particular the maternal health services, this court is "… reluctant to determine the questions raised in this petition. The Executive has the political and legal responsibility to determine, formulate and implement policies of government … This court has no power to determine or enforce its jurisdiction on matters that require analysis of the health sector government policies, make a review of some and let on, their implementation. If this court determines the issues raised in the petition, it will be substituting its discretion for that of the Executive granted by law[25]….

The petitioners appealed the decision of the Constitutional Court in the Supreme Court[26], which held that the petitioners had raised questions of constitutional interpretation within the ambit of Article 137 of the Constitution. Thus, the Constitutional Court should hear the petition in order to determine whether the allegations therein entitle the petitioner to the redress sought.

Justice Kisaakye observed that the political question doctrine has limited application in Uganda's current constitutional order and the Constitutional Court was established to hear disputes where private citizens allege that action or inaction by the Executive or Parliament contravenes or is inconsistent with the Constitution. Chief Justice Katureebe stressed that where a citizen alleges that a health policy or actions and omissions made under that policy contravene the Constitution, the Constitutional Court has a duty to determine whether such action or omission indeed contravenes the Constitution. The learned Chief Justice also emphasized that the notion of separation of powers is not absolute. He observed that since the petition raised constitutional issues regarding the right to health and medical services under National Objectives XIV and XX

[25] At p. 15.

[26] *Center for Health, Human Rights and Development (CEHURD) & 3 Others v Attorney General*, Supreme Court Appeal No. 1 of 2013.

of the Constitution respectively, the Constitutional Court would have to consider where the right to health falls under the Constitution and whether government had taken 'all practical measures to ensure basic medical services' as required by National Objective XX. The Chief Justice agreed with the Constitutional Court that questions of negligence and the attitude of health workers towards patients did not require constitutional interpretation and would be properly handled in the High Court. In a unanimous decision, the Supreme Court ordered the Constitutional Court to hear the petition on its merits.

Following the order of the Supreme Court, the Constitutional Court heard and unanimously allowed the petition. The court held that the Government's omission to adequately provide basic maternal health care services in public health facilities violates the right to health, right to life and women's rights. That government's omission to adequately provide emergency obstetric care in public health facilities, which results in obstetric injury, subjects women to inhuman and degrading treatment.

Justice Barishaki Cheborion reaffirmed that the right to health is a fundamental right which States ought to respect, protect, uphold and promote. Emphasizing the indivisibility of human rights, the learned judge stated that 'the right to health, life and human dignity are inextricably bound. There can be no argument that without the right to health, the right to life is in jeopardy'[27]. He further stated:

> The right to health, human dignity and life of women [are] protected both under international law and our Constitution. The right encompasses access to adequate maternal health care. … Maternal health has a direct relation to the physical attributes of women and as such their reproductive health forms an integral part of the health of a woman and for this reason, it is conceived as part and parcel of human rights of women. The right to health of a woman forms an integral part of her right to life, right to equality, right against torture, cruel, degrading, and inhuman treatment.[28]

The Constitutional Court made a number of declarations and orders. The court declared that the government's omission to adequately provide basic maternal health care services in public health facilities violates the rights to health, life and women's rights. The court also declared that the government's omission to adequately provide emergency obstetric care in public health facilities resulting into obstetric injury which subjects women to inhuman and degrading treatment. The court ordered the government to prioritize and provide sufficient funds in the national budget for maternal health care within the next two financial years (2020/21 and 2021/22); to ensure that staff who provide maternal health services are fully trained and all health centers are fully equipped; and to compile and submit to Parliament a full audit report on the status of maternal health in Uganda. The court awarded the 3rd and 4th petitioners a total of one hundred and fifty-five million shillings (155,000,000/=) Ugandan shillings each for general and exemplary damages.

[27] At p. 36.
[28] At p. 53.

Advocacy

SL is an important tool for advocating human rights, including maternal health rights. However, advocacy inside the courtroom is only one part of SL. SL is but only one of the many strategies to advocate for maternal health rights. In preparing for and litigating the case, CEHURD engaged legal experts, including practicing lawyers and law academia, to discuss the salient legal issues involved in the case. Practicing advocates were also engaged to represent the petitioners in the case. CEHURD also held community dialogues in order to understand and appreciate the issues at stake. CEHURD, with other civil society networks, formed a diverse coalition (Coalition to Stop Maternal Mortality in Uganda) to implement a legal and advocacy strategy to challenge the preventable maternal deaths in Uganda. This Coalition met weekly and monthly to discuss strategies for advocacy around the case.

CEHURD engaged local and international media and ensured that they were present whenever the case was called for hearing. The organization also lobbied for free airtime in the electronic media. CEHURD organized peaceful demonstrations. Interested members of the public and members of CSOs were organized to go to court holding t-shirts, placards and banners with well-crafted messages such as '16 WOMEN DIE EVERYDAY DUE TO PREVENTABLE CAUSES'. Both print and electronic media captured most of the salient issues in the case, thereby raising the level of awareness and insight into the maternal mortality and morbidity questions in the country. The unacceptable number of preventable deaths of women due to a lack of maternal health goods and services was brought into the public domain. Because the court was takinga lot of time to fix the case for hearing, peaceful demonstrations were organized in Kampala, Arua and Mityana to send a message that this was an issue affecting women beyond Kampala.

As part of advocacy efforts, CEHURD conducted some judicial colloquia and law moot competitions, involving right to health-related questions, in universities, presided over by constitutional court justices.[29]

Impact

Petition 16 is the first case to successfully challenge the government for failure to meet its constitutional obligations in respect of maternal health rights. An opportunity to clarify on the normative scope and content of maternal health rights in Uganda was lost in the ill-fated case of *Joyce Nakacwa v The Attorney General and others*.[30]

In the Joyce Nakachwa case, the petitioner delivered a baby girl by the roadside and proceeded to a public health facility with the baby still attached to her after birth so that the birth process may be completed. At the facility, she received no medical/maternity care whatsoever and was referred to Mulago National Referral Hospital but without a referral letter. The petitioner was forced to walk immediately thereafter, in spite of the fact that she was still bleeding and weak from the delivery and her clothing was all stained with blood. She failed to walk due to dizziness

[29] Interview with Ms. Nakibuuka Noor Musisi, Deputy Executive Director, Programmes, CEHURD.
[30] (Constitutional Petition No. 2 of 2001).

from bleeding and was forced to sit outside in the early morning with a baby that was only about two hours old. The petitioner was later rescued by a person passing by on her way to work and taken to a clinic in Kireka and subsequently to her sister's home. Later that day, she returned to her residence in Nakawa Trading Centre. At the instigation of some boda boda (motorcycle) cyclists, she was accused by residents and the Local Council (LC) Chairperson (third respondent) of having stolen the child she was carrying. The residents entered the petitioner's room and led her to the third respondent's home where she was subjected to mob justice. She was subjected to unlawful vaginal examination by the third respondent and another person, using polythene bags for gloves, in full view of both male and female residents of the area.

The petitioner was taken to Jinja Road Police Station with her baby. She was released on police bond after five days but her baby had been taken to Sanyu Babies Home where unfortunately it died. The petitioner alleged violation of a number of rights including the right to life[31]; freedom from torture, cruel, inhuman and degrading treatment;[32] protection of women's human rights;[33] children's rights;[34] and right to liberty.[35] The AG raised a preliminary objection that the matters before court did not raise questions for constitutional interpretation as per Article 137 of the Constitution. In a unanimous decision, the court dismissed the preliminary objection and held that it had jurisdiction to entertain matters that would otherwise fall under Article 50 (enforcement of rights and freedoms), if this is done in the process of constitutional interpretation under Article 137 of the Constitution. However, as fate would have it, the petitioner died before her case could be heard on its merits and it abated.

Almost 20 years after the Joyce Nakacwa case, Constitutional Petition 16 was decided. It created a precedent: the right to health is now justiciable in Uganda and the state has the obligation to respect, protect, promote, uphold and fulfill it. In interpreting objectives XIV, XX, 8A and Article 45 of the Constitution, the Constitutional Court clearly made an unequivocal statement: the right to health is now firmly established in Uganda's jurisprudence.[36]

Beyond the juridical impact of Petition 16, maternal health issues were debated in Parliament culminating in a Parliamentary Resolution on maternal health. Petition 16 led to increased civil society activism and budgetary increment to the health sector. For example, in 2012, Parliament and the Executive were pressurized by the Coalition to Stop Maternal Mortality in Uganda and allocated 49.5 billion shillings to undertake substantial health worker recruitment exercise in order to increase the number of priority cadres of professional health workers in district health facilities[37]. In the national budget for Financial Year 2022/2023, the Government of Uganda increased the overall budget allocation to the health sub programme from 3.1 trillion in the 2021/22 FY to 3.7 trillion in the 2022/23 FY as reflected in the budget speech. This is the highest allocation the health sector has received. It also represents the highest single year increment to the health sector budget ever.

31. Article 22(1).
32. Articles 24 and 44.
33. Article 33(3).
34. Article 34(1).
35. Article 23(4).
36. Interview with Mr. David Kabanda, Executive Director, Centre for Food and Adequate Living Rights (CEFROHT).
37. Interview with Ms. Nakibuuka Noor Musisi, Deputy Executive Director, Programmes, CEHURD.

Since maternal health does not have a specific vote, it is difficult to know how much of the budget increment is for maternal health. However, the increment for specific maternal health commodities such as blood is a good indicator as the budget for blood increased from UGX 17 billion in 2021/2022 to UGX 23 billion in the 2022/2023 budget. Part of the increment to the health sector is to cater for salary enhancement for health workers and the recruitment of additional 400 health workers to reduce the current staffing gap from 1,900 health workers to 1,500 across the different cadres. At this point, however, it may not be possible to ascertain how many of the 400 staff to be recruited would be for maternal health. CEHURD has interacted with Ministry of Health officials who are grateful for the fact that the case has brought the need for increased funding for health to the attention of relevant government agencies, including the Ministry of Health. Various hospitals such as Nakaseke and Mityana have been renovated[38]. Thus, Petition 16 illustrates that SL is an important tool for demanding accountability from the state, its organs and agencies. SL places maternal health rights on the agenda of these organs, including the judiciary and the legislature.

As pointed out above, the case also led to the establishment of a Coalition to Stop Maternal Mortality in Uganda. This is a coalition of community-based and civil society organizations working in the area of health rights. The coalition members meet regularly to discuss various health related issues, including controversial ones such as access to safe abortion, given that unsafe abortions significantly contribute to maternal mortality and morbidity in the country. As a result of Petition 16, there has been increased awareness of maternal health as a public health issue and there have also been advances in strategic interest litigation as a tool for realization of human rights.[39] The case illustrated the point that SL is possible with effective and sustained advocacy.

It is important to point out that some of the vital components of the right to health emphasized by the court in Petition 16 have been incorporated in the Public Health (Amendment) Act, 2022. Section 76 of the amended Act inserted section 110A in the Principal Act, which provides for the government's obligation in public health services. The section provides that the government shall, among others, 'take all practical measures to ensure the provision of basic medical services to the population'; 'ensure that all Ugandans have access to health services'; and 'provide health facilities and opportunities necessary to enhance the welfare of women to enable women realize their full potential and advancement'.

4.1.2 Center for Health, Human Rights and Development, Mugerwa David, Nantongo Gloria, Nalukwago Suzan & Namugerwa Grace (Suing their next friend Mugerwa David) v. Nakaseke District Local Government (Civil Suit No. 111 of 2012)

The Context

A person aggrieved by the decision of a medical practitioner may decide to lodge a complaint with the Medical and Dental Practitioners' Council or pursue litigation in order to hold the practitioner or a hospital or health care institution they are working for accountable. The hospital or institution may be held vicariously liable for damage caused by negligence of its staff. Medical malpractice

[38] Interview with Ms. Nakibuuka Noor Musisi, Deputy Executive Director, Programmes, CEHURD.
[39] Interview with Ms. Nakibuuka Noor Musisi, Deputy Executive Director, Programmes, CEHURD.

litigation is largely based on the law of negligence although civil liability may also arise for breach of contract in case of private practitioners.

Where the claim is based on negligence, the plaintiff must prove three essential elements: that the defendant medical practitioner owed him or her a duty of care; that there was a breach of that duty by the failure of the defendant to provide care in accordance with a standard required by the law; and that the plaintiff suffered injury or harm (damage) as the result of the breach, which was not so unforeseeable to be regarded in law as remote (Donoghue v Stevenson [1932] AC; Lamb v Camden LBC (1981) QB 265; Atcero v Women's Hospital International and Fertility Centre and others, Civil Suit No. 298 of 2012). But proving medical negligence may be a daunting task. The particulars of negligence must be specifically pleaded and proved. Given this situation, CEHURD decided not to pursue the medical negligence option and opted for enforcement of constitutional rights. CEHURD also wanted to demonstrate that human rights arguments can be used to address questions of medical negligence.

Through contacts with the Uganda National Health Consumers Organization (UNHCO), CEHURD learnt of a one Mugerwa David who had lost a wife due to the negligence of the medical doctor on duty.[40] CEHURD had a number of alternatives: either to report a complaint to the Medical and Dental Practitioners' Council; or pursue a claim for damages under medical negligence; or seek enforcement of constitutional rights.

In Petition 16, the Constitutional Court had raised a question as to why the petitioners had not sought enforcement of rights under Article 50 of the Constitution. Thus, although the case smacked more of a medical negligence claim, CEHURD decided to proceed under Article 50 of the Constitution, which allows an organization to bring an action on behalf of others whose rights have been violated or are threatened with violation. CEHURD also decided to proceed against a local government (Nakaseke District Local Government), which has a supervisory role as per the Local Governments Act.[41]

Litigation

The plaintiffs, brought an action on behalf of the deceased, Irene Nanteza, challenging the violation of her human rights. The plaintiffs sought declaratory orders and damages on ground that the deceased's failure to access health services in a public health service facility violated her right to equality and freedom from discrimination;[42] right to life;[43] freedom from cruel, inhuman and degrading treatment;[44] and women's rights.[45]

In this case, Nanteza was admitted at the defendant's hospital with obstructed labour. The nurse called the doctor on duty who delayed his arrival. Nanteza, who had been in labor for about

40. Interview with Ms. Nakibuuka Noor Musisi, Deputy Executive Director, Programmes, CEHURD.
41. Cap 243 Laws of Uganda
42. Article 21.
43. Article 22(1).
44. Article 24 and 44(a).
45. Article 33(3).

eight hours, died due to lack of emergency obstetric care. It was alleged by the plaintiffs that the deceased had an obstructed labor condition but did not receive the appropriate medical care and attention due to the absence of the doctor assigned to her. The judge visited the defendant's hospital in order to acquaint himself with some of the facilities such as the theater, HIV clinic and maternity ward, which were mentioned in the evidence. The court held that her right to basic medical care had been violated due to absence of the doctor on duty. That because of the doctor's absence, she did not receive the necessary care to overcome the condition she was in, leading to a violation of her human and maternal rights guaranteed under the Constitution, which obliges the state to 'protect women and their rights, taking into account their unique and natural maternal functions in society'[46]. The court also held that the rights of her children and spouse had been violated, since through the doctor's negligence, they had been deprived of their mother and wife respectively. The court awarded the plaintiffs thirty-five million Uganda shillings (UGX 35,000,000/=) in damages.

Advocacy

Like in Petition 16, CEHURD engaged the media. It called a press conference when the case was filed. It also involved the media when the judge sought to visit the hospital. Although visiting the locus quo (place where the cause of action arose or scene of the event) usually occurs in land disputes, in this case, the judge visited the hospital. He was able to understand and appreciate the state of the relevant maternal health facilities and services before ruling on the matter. The media reported on the matter and raised awareness on the issues at stake. However, the judge was unhappy that the media was invited to cover the visit. The judge stated: 'Finally, I must reprimand, counsel for the plaintiffs, who without leave of court, invited a horde of photographers and video recorders, to capture the state of … Nakaseke Hospital during the court's visit in a manner that disrupted the operations of the hospital during the visit'. The judge's observation in this case was clear that perhaps in SL cases, the advocate needs to notify court where engagements involve visiting of locus.

Impact

The case set a precedent in the struggle for the realization of maternal health rights in the country: that medical negligence can violate a person's constitutional rights. It demonstrated that an aggrieved citizen can use human rights arguments to address questions of medical negligence. It set precedent on access to emergency obstetric care being a right in Uganda. The case offered a mechanism to demand accountability from the government as to how it is investing in the promotion of socio-economic rights such as the right to health. The case also illustrated the point that a local government can be held vicariously liable for the negligence of employees at a public hospital. The case led to the renovation of the hospital and the streamlining of its administrative structures. The case also opened up a relationship between civil society organizations and the local government, culminating into the training of district officers, including health workers in the area of health and human rights.[47]

[46] Article 33.

[47] Interview with Ms. Nakibuuka Noor Musisi, Deputy Executive Director, Programmes, CEHURD.

4.1.3 Center for Health, Human Rights and Development, Mubangizi Michael & Musimenta Jennifer v. Executive Director, Mulago National Referral Hospital & Attorney General (Civil Suit No. 212 of 2013)

The Context

The stealing or switching of babies in public hospitals has, over the years, been reported in the media.[48] There have been allegations of 'baby thieves or abductors' collaborating with health workers at the hospitals. Mothers who lose their babies under unexplained or unclear circumstances are indeed subjected to agony and psychological torture. When Musimenta Jennifer and Mubangizi Michael lost their baby at Mulago National Referral Hospital, they reported the matter to the police and later contacted the Uganda Human Rights Commission that referred it to CEHURD who took it up. Albeit the case raised questions of negligence of hospital staff, CEHURD strategically decided to frame the issues in terms of violation of constitutional rights and their enforcement.

Litigation

The third plaintiff (Musimenta Jennifer), a wife to the second plaintiff (Mubangizi Michael), delivered two babies at Mulago National Referral Hospital. On 15th March 2012, she was discharged with only one baby. The plaintiffs contended that the third plaintiff gave birth to two live babies while the defendants argued that one of the babies was born dead. The second and third plaintiffs reported the loss of their baby to the police. On 17th March 2012, they were given a dead baby by a mortuary attendant at the hospital. The second and third plaintiffs rejected the dead baby and a DNA examination confirmed that they had no biological connection with the body handed over to them by the mortuary attendant. The court found that the death of the baby was a result of negligence of the hospital staff.

The judge creatively cited and applied relevant provisions in international and regional human rights instruments on the right to health and held that the psychological torture inflicted on the second and third plaintiffs amounted to a violation of the right to health, including SRHR. The court made a number of declarations and orders and these included; that the police should conclusively investigate the disappearance of the baby and report to court within six months; the midwife who handled the baby should be held to account for the movement of the baby from her care; and Mulago hospital should take steps 'to ensure and/or enhance the respect, movement and safety of babies, dead or alive, in its facilities'. The court also ordered the Executive Director, Mulago Hospital to make written reports every four months for two years regarding the steps or measures taken in fulfilling the foregoing orders and serve them on CEHURD. The court further ordered that CEHURD shall have unfettered access to Mulago hospital to continuously oversee

[48] See for example, Shifa Mwesigye, 'Uganda: pain of having your baby stolen' The Observer, 25 July 2013; 'Woman arrested for stealing baby from Mityana Hospital' The Independent, 28 October 2022; Emmanuel Eumu, 'Woman held over baby theft' The Daily Monitor, 5 January 2023; 'Horror: dealing with the agony of a stolen baby' The Daily Monitor, 3 September 2013; 'Who is stealing babies from mothers in hospitals?' New Vision, 29 August 2013; Rodney Muhumuza 'Newborn babies being stolen at a top Ugandan hospital' 4 August 2023.

the implementation of the court orders. CEHURD was ordered to ensure that Musimenta Jennifer and Mubangizi Michael access psycho-socio care and counseling services at Mulago Hospital's cost.

Advocacy

CEHURD engaged practicing lawyers and law academia in preparation for the case. The media was involved in disseminating the case throughout the court process. Indeed, there were various reports in both the print and electronic media concerning the case.[49]

Impact

The case clarified on the normative scope and content of the right to health and the obligations of the state to respect, protect and fulfill the right. Although this case was decided by a judge of the High Court, it was substantially cited with approval by the Constitutional Court.[50] The case shows that the right to health is now firmly established in our jurisprudence and is justiciable, that is, it can be enforced by the courts.

The decision lays a number of lessons for other judges handling socio-economic rights such as the right to health. In the first instance, a judge can apply relevant international and regional human rights instruments to a case before them. Secondly, the right to health should be interpreted in an interdependent and interrelated fashion. For example, the judge applied relevant civil and political rights such as freedom from torture, cruel, inhuman and degrading treatment; right of access to information; rights of the family; and children's health rights. Thirdly, judges should be innovative and creative. For example, although the plaintiffs had not requested for certain remedies, the judge issued orders to address certain health care system challenges at Mulago National Referral Hospital as illustrated above. Information coming out from the Women's Hospital in Mulago indicates that there have been no losses or theft of babies – a positive development that may be attributed to the court decision.[51]

It should be noted that in pursuance of the court order, CEHURD, on 24th March 2021, filed a report on the progress of implementation of the judgment delivered by court. The court had ordered that the police should conclusively investigate the disappearance of the baby in question. CEHURD made several follow-ups to ensure that police made a report regarding the disappearance of the child and filed it in court. Unfortunately, CEHURD has not yet received a copy of the said report. The court ordered that the midwife who handled the baby at birth should be held accountable for the movement of the baby under her care. CEHURD, through their lawyers, wrote to the Nurses and Midwives Council requiring the Council to investigate and undertake disciplinary action against the midwife. Albeit the Council heard the complaint in November 2018, the ruling hasn't yet been delivered.

[49] Interview with Ms. Nakibuuka Noor Musisi, Deputy Executive Director, Programmes, CEHURD.
[50] In Center for Health, Human Rights and Development & Others v. Attorney General Constitutional Petition No. 16 of 2011 above.
[51] Interview with Ms. Nakibuuka Noor Musisi, Deputy Executive Director, Programmes, CEHURD.

Mulago National Referral Hospital was ordered to take steps to ensure the respect, movement and safety of babies, dead or alive in its facilities. On 16th May 2018, CEHURD had a meeting with the representatives of Mulago National Referral Hospital to discuss the steps taken by the hospital in the implementation of the judgment. The hospital principal administrator stated that the hospital had taken steps to ensure the movement and safety of babies within the hospital premises. The Directorate of Obstetrics and Gynecology Manual, which contained Standard Operating procedures (SOPS) on how babies are handled in the hospital was developed. The SOPs explain, in an exhaustive fashion, how a pregnant mother is handled at the hospital from the time of admission up to the time of discharge.

On 30th October 2018, CEHURD, together with the hospital principal administrator conducted a monitoring visit at the New Mulago Specialized Women and Neonatal Hospital to assess the management of newborns. The monitoring visit found that progressive measures had been instituted at the hospital. The hospital adopted a routine where all births are registered in the birth registration book and the newborns are labeled upon birth. The hospital established a compassion ward where mothers who have lost their babies receive counseling. When a newborn dies, the midwife shows the mother the body of her deceased baby. Thereafter, the mother confirms the death in writing in the language she understands and the confirmation is witnessed by the attendant and midwife. The doctor certifies the death and the death certificate is issued. The baby is then wrapped and a bag is used to identify the body. The tag bears the following particulars: date and time of death; name, address and weight of the mother; and sex of the baby. The midwife should notify the mortuary attendants about the death. The mortuary attendant must sign for the body of the baby and witnessed by a midwife. Thereafter, the family of the deceased follows up the body at the mortuary.

Security at the hospital has been enhanced through the establishment of CCTV cameras in all corners of the hospital. The hospital has also installed baggage scanners at the main entrance of the hospital. At this entrance, there is mandatory registration of every patient or visitor. All bags and cars are checked when entering and exiting the hospital. There is restricted access to all units of the hospital and no patient leaves the hospital without a clearance form. Authorized hospital staff have to sign into the security systems and the security guards are deployed at the entrance of all units.[52]

The court ordered that CEHURD should ensure that the second and third plaintiffs access psycho-socio care and counseling services as part of their healing. These plaintiffs received psycho-social support at the New Mulago Specialized Women and Neonatal Hospital. All the money awarded was duly received by the plaintiffs.[53]

4.1.4 Center for Health, Human Rights and Development (CEHURD), Mayanja Ann Angella & Wasswa Benson V. Registered Trustees of Roman Catholic Diocese of Masaka, Mutebi George William, Dr. Moses Male Kawuma, Medical Superintendent Villa Maria Hospital, Civil Suit No. 26 of 2017

[52] All the above information is from the report filed by CEHURD in court. It was availed to the consultant by Ms. Nakibuuka Noor Musisi, the Deputy Executive Director, Programmes, CEHURD.
[53] Interview with Ms. Nakibuuka Noor Musisi, the Deputy Executive Director, Programmes, CEHURD.

The Context

A person aggrieved by the decision of a medical practitioner may decide to lodge a complaint with the Medical and Dental Practitioners' Council or pursue litigation in order to hold the practitioner or a hospital or health care institution they are working for accountable. The hospital or institution may be held vicariously liable for damage caused by negligence of its staff. Medical malpractice litigation is largely based on the law of negligence although civil liability may also arise for breach of contract in case of private practitioners.

Where the claim is based on negligence, the plaintiff must prove three essential elements: that the defendant medical practitioner owed him or her a duty of care; that there was a breach of that duty by the failure of the defendant to provide care in accordance with a standard required by the law; and that the plaintiff suffered injury or harm (damage) as the result of the breach, which was not so unforeseeable to be regarded in law as remote (Donoghue v Stevenson [1932] AC; Lamb v Camden LBC (1981) QB 265; Atcero v Women's Hospital International and Fertility Centre and others, Civil Suit No. 298 of 2012). But proving medical negligence is a daunting task. The particulars of negligence must be specifically pleaded and proved. Given this situation, CEHURD decided to pursue enforcement of human rights and freedoms under Article 50 of the Constitution and to some extent, medical negligence albeit the particulars of negligence were not stated in the plaint. In other words, medical negligence was not specifically pleaded.

Litigation

On 23th February 2016, the third plaintiff, while playing with his friends, put a motorcycle ball bearing on his penis before going to bed. Next day, in the morning, the third plaintiff was rushed to Villa Maria Hospital by the second plaintiff for emergency treatment to remove the ball bearing from his penis. On arrival at the hospital, the second and third plaintiff were received by a receptionist who informed them that all the doctors were not on station except the second defendant. The second defendant informed the second plaintiff that he would be able to perform an emergency operation to remove the motorcycle ball bearing that was stuck around the boy's penis.

The second defendant took the third plaintiff to a treatment room where he cut off the third plaintiff's penis. The second plaintiff heard the boy (third plaintiff) screaming in pain. After some time, another health worker, Dr. Emmanuel Kalemera Ssenyondo, entered the treatment room to attend to the boy. Dr. Ssenyondo summoned the second plaintiff to the treatment room to look at what had been done to the boy and sign consent forms prior to him carrying out the procedure. After carrying out an examination, Dr. Ssenyondo decided against operating on the boy and instead referred him to St. Francis Hospital Nsambya for better management. The boy was admitted at this hospital where the wound was dressed. Because of the gravity of the injury, further medical care was sought from other medical facilities, including Mulago National Referral Hospital, Nakasero Hospital, Comprehensive Rehabilitative Services Uganda (CORSU) and consequently the boy was advised to travel abroad for a reconstructive surgery.

The plaintiffs contended that the first and third defendants were vicariously liable for human rights violations perpetrated against the second and third plaintiffs by the second defendant. That the act of amputating the third plaintiff's penis by the second defendant was a violation of the third plaintiff's right to health, including Sexual and Reproductive Health, and freedom from torture, cruel, inhuman and degrading treatment. The plaintiffs further contended that the actions of the second defendant of amputating the third plaintiff's penis have resulted in unexpected, unplanned expenditures and immense suffering on the part of the second and third plaintiffs. The plaintiffs also averred that the second defendant was negligent in performing the emergency operation resulting into violations of the second and third plaintiffs' human rights.

The plaintiffs sought the following declarations from court: that the defendant violated the third plaintiffs' right to health contrary to Articles 8A, 45, Objectives XIV(b) and XX of the Constitution; that the acts of the second defendants violated the second and third plaintiffs' right to freedom from torture, cruel, inhuman and degrading treatment; and that the first and second defendants are vicariously liable for the acts of the third defendant, its employee. The plaintiff prayed for the following orders: an order for special damages to the second plaintiff for costs incurred in medical expenses of the third plaintiff's health; and an order that the defendants pay general and punitive damages to the second and third plaintiffs for the present and future suffering of the third plaintiff and for the violations of the rights to health and life and freedom from torture, cruel, inhuman and degrading treatment.

Impact

The case did not proceed for trial as it was settled out of court. In a consent judgment entered by both parties on 10th May 2022, the defendants agreed to pay to the second and third plaintiffs a sum of One hundred Million shillings (UGX 100,000,000/=) in full and final settlement of the plaintiffs' claim. It was also agreed that with the help of the first plaintiff, the first and second defendants would take steps to ensure provision of quality health services, safety of patients and effective supervision of its health workforce at Villa Maria Hospital and to submit a report to the first plaintiff on measures taken within six months from the date of endorsement of the consent judgment by court.

4.1.5 Center for Health, Human Rights and Development (CEHURD), Natumbwe Ritah & Kitaka Ronald V. The Registered Trustees for Mengo Hospital, Dr. Rose Mutumba – Medical Director, Mengo Hospital, Dr. William Bukenya – Deputy Medical Director Mengo Hospital, Nassali Sylvia Sophie, Namuli Sophie & Dr. Martha Namusobya, Civil Suit No. 176 of 2015

The Context

A person aggrieved by the decision of a medical practitioner may decide to lodge a complaint with the Medical and Dental Practitioners' Council or pursue litigation in order to hold the practitioner or a hospital or health care institution they are working for accountable. The hospital or institution may be held vicariously liable for damage caused by negligence of its staff. Medical malpractice

litigation is largely based on the law of negligence although civil liability may also arise for breach of contract in case of private practitioners.

Where the claim is based on negligence, the plaintiff must prove three essential elements: that the defendant medical practitioner owed him or her a duty of care; that there was a breach of that duty by the failure of the defendant to provide care in accordance with a standard required by the law; and that the plaintiff suffered injury or harm (damage) as the result of the breach, which was not so unforeseeable to be regarded in law as remote (Donoghue v Stevenson [1932] AC; Lamb v Camden LBC (1981) QB 265; Atcero v Women's Hospital International and Fertility Centre and others, Civil Suit No. 298 of 2012). But proving medical negligence is a daunting task. The particulars of negligence must be specifically pleaded and proved. Given this situation, CEHURD decided to pursue enforcement of human rights and freedoms under Article 50 of The Constitution and in the alternative, medical negligence.

Litigation

On 1st January 2015 at around 5:30pm, the second plaintiff, in the company of her mother (the attendant), reported at Mengo Hospital for delivery by way of a cesarean section and paid the necessary hospital bills. A nurse examined the second plaintiff and informed her that she and her expected baby were in good condition. After about 30 minutes, two student nurses entered the second plaintiff's admission room; a student nurse administered an injection to the second plaintiff's right hand. However, the nurse did not administer the injection properly and as a result, blood spilled on the bed sheets. The second plaintiff requested the other student nurse who was also in the room to administer the injection in the left hand but she refused. Both student nurses left the room. The second plaintiff was taken to the theatre where the nurse explained to her the available anesthesia options for a cesarean section and she opted for spinal anesthesia. The second plaintiff had a successful operation and gave birth to a baby boy. After about 30 minutes of assessment by a doctor, the second plaintiff and her baby were taken back to the admission room. After a few minutes, the second plaintiff noticed that the baby was making unusual noise when breathing and immediately called a nurse. The baby was taken by a nurse to the hospital nursery where he spent a night under observation.

The next day, the doctor examined the baby and found him in a good condition as he was feeding and resting well. At around 12 am, the fifth defendant entered the second plaintiff's room holding a tray with two syringes (one big and the other small) that already contained mixed medication. The fifth defendant injected the baby with a big syringe while she used the small one on the mother (second plaintiff). Suddenly after injecting the baby, the latter turned blackish and started crying and gasping for breath. The fifth defendant stood in the room terrified and confused. The second plaintiff cried out for help and took the baby to two nurses who rushed her to an emergency room, put him on oxygen and later transferred him to the nursery. The second plaintiff went back to her admission room and was later informed that the baby had died. The body of the baby was taken by the third plaintiff to the mortuary for a post mortem, which revealed that he had died of hypoxia (oxygen deficiency).

The plaintiffs alleged that the acts and omissions of the defendants violated various rights, including life, health, freedom from torture, cruel, inhuman and degrading treatment, and access to information for which they claimed general damages. In the alternative, the plaintiffs pleaded medical negligence on the part of the defendants and claimed general and punitive damages. The plaintiffs prayed for the following declarations: that the failure by the first, second and third defendants to ensure that the fifth defendant was supervised while administering treatment to the second plaintiff and the baby was a violation of and a threat to the right to life guaranteed by Article 22(1) of the Constitution; that the first, second and third defendants' failure and omission to ensure that the second plaintiff and the baby received appropriate health care was a violation of the right to access quality care contrary to Articles 8A, 45 and Objectives XIV(b) of the Constitution; and that the failure of the fourth defendant to treat and take care of the second plaintiff and the baby was a violation of the right to life, freedom from inhuman and degrading treatment and the right to health contrary to Articles 22(1), 24, 8A, 45 and Objective XIV(b) of the Constitution.

Other declarations sought by the plaintiffs are: that the failure of the fourth defendant, being a skilled health worker, to supervise the fifth defendant while administering treatment to the baby and the second plaintiff was a violation of the right to receive quality health care contrary to Articles 22(1), 24, 8A, 45 and Objectives XIV(b) of the Constitution; that the act of the fourth defendant of administering treatment to the baby and the second plaintiff without supervision denied the baby and the mother the right to receive quality health care contrary to Articles 22(1), 24, 8A, 45 and Objectives XIV(b) of the Constitution; that the failure of the first, second and third defendants to provide all medical records of the second plaintiff and the baby was a violation of the right to access health information contrary to Articles 8A, 41(1), 45 and Objective XIV of the Constitution; and that the defendants' failure and omissions to accord proper health care resulted in the death of the second and third plaintiff's baby. The plaintiffs prayed for an order that the defendants pay general and punitive damages to the second and third plaintiffs for violating their rights to health, life, access to information and freedom inhuman and degrading treatment.

The defendants denied the allegations by the plaintiffs and argued that the latter are not entitled to any redress under Article 50 of the Constitution. The defendants contended that the second plaintiff was admitted on the 21st January 2015 where she delivered a baby by cesarean section but he developed breathing problems and was admitted to the premature unit. The baby was started on antibiotics and returned to the mother on the third day and he was continued on intravenous antibiotics and other medication. However, the baby's condition changed and soon after, he was rushed to the premature unit, put on oxygen for resuscitation given that he was not breathing well. After the post mortem report, which found that the baby died of hypoxia, a toxicology examination was carried out. According to the defendants, the toxicology examination did not implicate them in any wrongdoing. Consequently, the defendant denied all the allegations of medical negligence on their part.

However, the case did not proceed for trial as it was settled out of court. By a consent judgment dated 22nd November 2018, the first defendant agreed to pay to the second and third plaintiffs a sum of UGX 35,000,000/= as full and final settlement of the plaintiffs' claims against all the defendants.

Advocacy

CEHURD conducted legal experts' meetings with lawyers to discuss and develop the pleadings, written submissions and generally strategize for the hearing of the case.

4.1.6 Center for Health, Human Rights and Development (CEHURD) v Attorney General, Miscellaneous Cause No. 235 of 2019

The Context

In 2018, the President of the Republic of Uganda officially commissioned Mulago Specialized Women's and Neonatal Hospital. The hospital, which is a component of Mulago National Referral Hospital, the largest hospital in the country, offers specialized health care services primarily through referral including emergency obstetric care services, treatment of cervical cancer, repairing of fistulas, IVF and many other conditions related specifically to the reproductive health of women and neo-nates. A loan was secured to construct the hospital, procure equipment and also train a few selected health workers in specialized maternal and neonatal areas. The Government developed a pay policy setting fees for people who want to access the specialized hospital. The services are classified as Standard VIP, and VVIP services and everyone who requires services from the hospital must pay prior to receiving treatment. Thus, only those women who can afford to pay may easily access care at the hospital.

Litigation

The applicant sought the following declarations from court: that the act of turning a public service into a private service at Mulago Specialized Women's and Neonatal Hospital is a retrogression in the provision of maternal health services, including emergency obstetric services and child health care services and is a violation of the right to health, women's rights, and children's rights; and that the act of charging a fee in order to access the hospital restricts access to maternal and child health services on grounds of sex and economic standing, which is a violation of the right to equality and freedom from discrimination. Other declarations sought by the applicant were: that the establishment of a Waiver Committee to access the capacity of clients to pay for maternal and child health care services at the hospital is a threat to the right to life and health; and that the act of turning a public service into a private service at the hospital without prior popular participation is not justifiable in a free and democratic society.

The applicant prayed for the following orders: a freely accessible public national referral wing be established within the hospital; Parliament of Uganda, through the Health Committee, investigates the set up and operations of the waiver committee and the pay policy and make recommendations to the hospital within six months from the date of the ruling and file a report to the court and serve a copy on the applicant. Other orders prayed for were: the Uganda Human Rights Commission conducts a human rights impact assessment of the charging of fees for maternal and child health care services at the hospital within six months from the date of the ruling and file a report to the court and serve a coy on the applicant; and the Equal Opportunities Commission

(EOC) carries out an audit on the impact of charging fees for maternal and child health care services at the hospital within six months from the date of the ruling and file a report to the court and serve a copy on the applicant.

The respondent contended that the government obtained a loan and established the hospital for women in order to enhance their welfare and that not all patients attended to at the hospital pay for the services rendered. Besides the hospital, all other public hospitals and facilities offer free basic health care services. The respondent further averred that the hospital provides advanced specialized health care services, which has enabled patients with complicated maternal and neonatal health problems to be treated within the country and that referrals abroad for specialized care have reduced largely due to the existence of the hospital. That there is a waiver system for patients who are unable to pay for the services at the hospital and that all patients are attended to irrespective of their economic status. In dismissing the application, the court stated:

> There is no evidence by the applicant to show that some people have not been able to access services at the facility for failure to pay money as required at the facility. No evidence has been presented to show that by charging fees at MSWNH [the hospital], the respondent has failed in its obligation to protect women and children's rights as provided under the 1995 Constitution. … I find that the evidence presented does not show that there is retrogression in the provision of maternal and child health care services at MSWNH.

Advocacy

CEHURD held legal expert meetings to conceptualize the case, discuss and strategize for the hearing of the case, including preparing pleadings and submissions before court. CEHURD also engaged print and electronic media on matters concerning the case.

Impact

This was a missed opportunity for the court to pronounce itself on the economic accessibility of services at the Mulago Specialized Women and Neonatal Hospital, a public hospital funded by the taxpayer. This is retrogression in the provision of maternal and child health care services because only those who can afford such care can access it.[54] Yet, under the government's obligation to fulfill the right to health, General Comment No. 14 of 2000 states that the state should facilitate and provide health services to those, who by their own means, are unable to access such services.

Although the learned judge who presided over the case seemed not to appreciate the human rights issues at hand, this application was largely dismissed for a lack of evidence on the part of the applicant. It would have been helpful if the applicant had obtained evidence by way of affidavit from women who had been denied services at the hospital due to non-affordability of the fees charged.

54. Interview with Nakibuuka Noor Musisi, Deputy Executive Director, Programmes, CEHURD.

4.1.7 Kasumba Simon Peter v Kiboga Local Government, Human Rights Commission Complaint No. 32 of 2016

The Context

The Uganda Human Rights Commission (the Commission) is established under Article 51 of the Constitution of the Republic of Uganda. One of the functions of the Commission is 'to investigate, at its own initiative or on a complaint made by any person or group of persons against the violation of any human right'[55]. Unlike the court process, which is cumbersome, the process before the Commission is informal and cheaper. Against this backdrop, Kasumba Simon Peter, who lost his wife at Kiboga General Hospital, due to the negligence of hospital staff filed a complaint with the Commission.

Litigation

On 7th May 2015, Joyce Bundoli (the deceased) was taken to Kiboga General Hospital by a one Ssaka Peter on instructions of the complainant and widower (Kasumba Simon Peter). The deceased was admitted in the maternity ward around 7:00 am by a nursing sister. At the material time, the complainant was hospitalized in China-Uganda Friendship Hospital, Naguru-Kampala. At around 1:00pm, the deceased was undergoing a lot of pain, and the attendant called a midwife for assistance. Upon examining the deceased, the midwife informed her that she was not yet due for labor and advised her to move around. At around 2:00pm, the deceased's water broke and when the attendant informed the midwife, she informed her that the deceased was not yet in labor.

The next day, the deceased was examined by the nursing sister who also informed her that she was not yet in labor. The deceased requested the nursing sister to put her on IV drip since her previous deliveries were induced by an IV drip but she declined and advised her to move around. The deceased had delivered all her four children from Kiboga General Hospital and the facility was aware of her medical history. Around 6:00 pm, the attendant requested the midwife to put the deceased on an IV drip as her condition was not improving but she declined and said that a mother who had given birth to four children could not be put on an IV drip because the uterus would rapture. Due to his hospitalization, the complainant requested his close friend, Sekibuule Charles go to Kiboga General Hospital and ensure that the deceased receives proper medical attention. Sekibuule arrived at the hospital at around 7:00 pm. Around 7:30pm, the attendant and Sekibuule saw an ambulance taking other expectant mothers to Hoima Regional Referral Hospital and requested the midwife to also take the deceased to Hoima but she declined and insisted that the deceased would deliver normally.

The deceased was immediately taken to the labor suite accompanied by the attendant. Around 12:00 am, the deceased cried out and informed Sekibuule that she felt something burst in her

[55] Article 52(1).

womb, causing a lot of pain and heat in her upper abdomen. Sekibuule noticed that the deceased could no longer move her legs and immediately called the midwife and requested her to call a doctor to operate on the deceased. The midwife declined and informed him that the deceased would deliver normally. Sekibuule later requested the midwife to put the deceased on an IV drip since she was continuously crying and yelling for help but she declined saying her uterus would rupture. A nurse put the deceased on a water drip at around 1:00 am but her condition did not improve and the nurse refused to call the doctor. Around 3:00 am, the deceased's condition worsened and the nurse immediately called the doctor to assess the condition of the deceased. The doctor examined her and immediately referred her to Hoima Regional Referral Hospital for an emergency operation. Upon arrival at Hoima Regional Referral Hospital, the deceased was examined by the health workers who observed that her uterus had raptured, and her baby was dead. She was taken to the theatre, operated and later transferred to the recovery room for monitoring the progress of her health. At around 2.30pm, the deceased's condition worsened and she was put on oxygen and at around 4:00pm, she passed on.

The complaint in the Commission is to the effect that Kiboga General Hospital (the hospital) failed to provide emergency obstetric care and management to the deceased who was experiencing an obstructed labor that led to her death and that of her unborn baby thereby violating her rights to life and health guaranteed under Articles 22(1) and 33(3) and Objectives XIV & XX of the Constitution and Section 30(1) and (2) of the Health Service Commission Act and Sections 1,4,5,13 and 14 of the Ministry of Health Patients' Charter. Kiboga District Local Government (the local government) failed to ensure that health workers at the hospital provided appropriate medical care to the deceased resulting in the violation of the deceased's right to life and health. That the local government failed in its duty to have a functional hospital by availing the necessary facilities in the theatre to carry out timely operations upon the deceased as required by Article 33(3) of the Constitution. That the hospital failed to take timely steps to call in a doctor or refer the deceased to Hoima Regional Referral Hospital for emergency obstetric care and management, thereby subjecting the deceased to gross psychological and physical pain, and thus violating her right to freedom from torture, cruel, inhuman and degrading treatment, contrary to Articles 24 and 44 of the Constitution. That the acts of the hospital staff violated the complainant's and his children's rights to a family, contrary to Article 31 of the Constitution. Finally, that the mental anguish, emotional distress and psychological suffering/pain occasioned by the hospital necessitated an award of punitive and general damages to the complainant and the children.

The complainant sought the following declarations from the Commission: that the failure by the hospital to provide adequate and timely emergency obstetric care to the deceased violated her rights to life and health; that the acts and omissions of the hospital violated family and children's rights by denying the children the right to be taken care of by their mother; that failure to refer the deceased to Hoima Regional Referral Hospital was a violation of the right of freedom from torture, cruel, inhuman and degrading treatment; and a declaration that emergency obstetric care is a human right.

The complainant also sought the following prayers: an order that the local government streamlines and maintains a functioning emergency care unit at the hospital and make periodic reports to the Commission every six months on the status of access to emergency obstetric care in the hospital; an order for the award of general and punitive damages to the complainant and his children; and that the Commission investigates the adequacy of human resources and availability of utilities such as water and electricity as key factors leading to violations of patients' rights in the hospital.

The respondent denied violating the deceased human rights and averred that when she was admitted at the Kiboga Hospital, she was 38 weeks pregnant with moderate anaemia and with a normal cervix, 4 cm dilated. That her labor was not progressing well as she still had moderate contractions at around 11.10am and the cervix had dilated to seven centimeters. When the deceased was examined by the midwife on duty, she was found to have cervical dystocia and blood was taken off for grouping and HB. The doctor referred only two pregnant women with complicated labor without the deceased to Hoima Regional Referral Hospital since she was not on her hospital bed. When the deceased returned to her bed, the midwife on duty examined her, gave normal saline 500ml as the ambulance was still at Hoima Regional Referral Hospital.

That next day, the doctor was called to examine the deceased again and found that her uterus had ruptured and recommended IV normal saline, blood for transfusion. However, the hospital did not have blood at the time and the deceased was referred to Hoima Regional Referral Hospital for further management. That uterus rapture is a rare condition in unscarred mothers and can be due to different causes such as abnormal placentation, uterine abnormalities, excessive uterotonics, which were not caused by the respondent. That the deceased had delivered her babies previously by spontaneous vaginal delivery and this being the seventh pregnancy was also expected to go well. That the hospital provided adequate care and attention to the deceased and that the complainant never came to the hospital at any time when the deceased was admitted. That it was negligent on the part of the complainant to leave his wife unattended to the whole time the wife was admitted at the hospital. That the doctor on duty adopted the normal practice that a professional or ordinary skilled person would have done. The case is pending hearing by the Commission.

Advocacy

This case, being litigated by the complainant and not CEHURD- CEHURD only provided legal support and opinion as well as direction to the complainant, did not receive any advocacy approaches from the institution.

4.2 Challenging Government's Failure to Issue a Policy on Comprehensive Sexuality Education.

4.2.1 Center for Health, Human Rights and Development (CEHURD) V Attorney General & Family Life Network, Miscellaneous Cause No. 309 of 2016

The Context

Children in Uganda face many Sexual and Reproductive Health challenges that may be attributed to a number of factors, including a lack of sexuality education, whose absence denies them critical information and lifesaving skills. A brief look at the available data may explain the dire situation many adolescents and young people find themselves in. Child marriage is a major contributing factor to teenage pregnancy with one in four girls either pregnant or having already had her first child by the age 19. An estimated 43% of women aged 25-49 were married before the age of 18[56]. One in four Ugandan women age 15-19 have given birth or are pregnant with their first child by the age of 18 years with teenage pregnancy more prevalent in rural than urban areas[57]. Pregnancy accounts for 22.3% of school dropouts among girls aged 14-18 years and 15-20% of dropout for girls is caused by child marriage and teenage pregnancy.[58] Only 21% of girls aged 15-19 are currently using any modern contraceptive method.[59]

The prevalence of modern contraceptive utilization among women aged 15-49 is only 38%.[60] In 2016, the contraceptive prevalence rate among adolescents was only 9% (UBOS, 2016). Thus, the majority of female adolescents in need of contraceptive methods in Uganda are not using any[61]. Yet, the use of contraceptives among adolescents and young people is one of the most cost-effective strategies to address many SRH challenges, including unintended pregnancies, early marriages and STIs.[62] Some of the unintended pregnancies end in abortion, which is an emotive, sensitive and complex subject in Uganda. In 2013, an estimated 314,300 abortions took place, which roughly translates to 14 of all pregnancies or a rate of 39 per 1000 women aged 15-49[63]. Out of these, approximately 57,000 abortions took place among adolescents aged 15-19 (Guttmacher Institute, 2018). In 2013, 93,300 women were treated for complications from unsafe abortion.[64]

There is also the challenge of HIV among adolescents and young people. In 2013, it was estimated that children below the age of 15 years accounted for 11% of the 1.6 million Ugandans living with HIV.[65] There has been a reduction in the number of new HIV infections among young people aged 15-24 from 29,000 in 2010 to 14,000 in 2020, roughly translating into a 53% decline of infections in this category. 37% of all new HIV infections were among young people aged 15-24

56. UBOS (2016) Uganda Demographic and Health Survey. Kampala: UBOS.
57. Republic of Uganda (2022) The National strategy to end child marriage and teenage pregnancy 2022/2023-2026/2027). Kampala: Republic of Uganda.
58. Ibid.
59. Ibid.
60. UBOS (2016) Uganda Demographic and Health Survey. Kampala: UBOS.
61. Sserwanja, Q et al 'Prevalence and factors associated with modern contraceptives utilization among female adolescents in Uganda' (2021) 21 BMC Women's Health 61
62. Mulubwa, C 'Framing contraceptive use motivations among adolescents and young adults living in informal settlements in Kira municipality, Wakiso district, Uganda' (2021) Front. Glob.Women's Health https://doi.org/10.3389/fgwh.2021.658515 (accessed 20 August 2023).
63. Guttmacher Institute (2017) 'Abortion and post abortion care in Uganda' www.guttmacher.org (accessed 18 August 2023).
64. Guttmacher Institute (2017).
65. UNICEF, 'HIV and AIDS: Improving HIV prevention and care for children and women' www.unicef.org (accessed 4 December 2022.

years with 79% of these infections among young women[66]. These numbers are still high.

Over the years, Uganda has promoted an 'abstinence only' policy in schools. On 17th August 2016, Parliament banned Comprehensive Sexuality Education (CSE) in all schools in Uganda. Against this backdrop, CEHURD decided to challenge in court the inordinate delay by the Ministry of Education and Sports to issue a policy on CSE.

Litigation

The applicants filed an application under Article 50(2) of the Constitution and Section 98 of the Civil Procedure Act and Order 52 Rule 1 of the Civil Procedure Rules seeking a declaration that the inordinate delay and omission by the Ministry of Education to issue a policy on CSE violates the right of access to information (Article 41) and education [Article 30 and 34(2)] of the Constitution; and Section 4(1) (c), (g) and (i) of the Children (Amendment) Act, 2016 and Section 4(1)(2) of the Education (Pre-primary, Primary and Post-primary) Act, 2008). The applicants also sought the following orders: an order quashing the ban on CSE materials in schools in the resolution of Parliament made on 17th August 2016; and an order that the Ministry of Education and Sports comes up with a policy on CSE within one month of the order being made.

The grounds for the application were that the inordinate delay by the Ministry to issue a policy on CSE had caused violation of human rights and freedoms enshrined in the Constitution and guaranteed under international law. The ban on CSE materials with no alternatives leaves children's and young people's rights to life and well-being threatened as they are vulnerable to abusive relationships, health risks associated with unintended pregnancies, and exposure to sexually transmitted diseases including HIV/AIDS. That the ban also denies children and young people the right to a proper transition to adulthood and that it is in public interest that a policy on CSE be immediately issued.

The respondent and an interested party (Family Life Network) opposed the petition. The respondent argued that the government recognizes sexuality education and not CSE. That the Ministry banned all unacceptable programmes and materials on CSE for a good reason, considering the issues surrounding it. That the content taught in some schools raised concerns of liberalization of sex among children and promotion of illicit sexual conduct such as homosexuality and masturbation. The respondent further contended that Parliament, by resolution, banned CSE to save Ugandan children after discovering that the unacceptable programmes, materials and content implemented by partners were illegally used in a number of schools. The respondent further contended that the ban by Parliament was a timely intervention to prevent the Ugandan children from being introduced to unacceptable liberal sex. That Parliament instructed the Ministry to come up with the National Framework on Sexuality Education that is appropriate, culturally and religiously sensitive to guide the delivery of sexuality education programmes, materials development and content without distortion and that the application is misconceived, vexatious and should be dismissed with costs.

The interested party argued that CSE is destructive to children because it contains things such

[66] Ibid.

as LGBT rights, abortion, and explicit graphic pornographic images to children as young as five years. That the ban does not have any effect on the right to education but instead safeguards the constitutional rights of parents to educate their children appropriately.

After reviewing international instruments on sexuality education, the court found that the inordinate delay and or omission to develop a CSE policy was a violation of Uganda's obligations under international law and Articles 30, 41 and 34(2) of the Constitution and Section 4(1) (c), (g) and (i) of the Children (Amendment) Act, 2016 and Section 4(1)(2) of the Education (Pre-primary, Primary and Post-primary) Act, 2008. The court ordered the Ministry to develop a CSE policy, working with relevant stakeholders. That this process should be completed within two years, with the Ministry reporting on progress to the Registrar of the High Court every six months.

Advocacy

CEHURD involved various coalitions and platforms during the litigation of the matter and carried out sensitization of the public on the critical importance of CSE. CEHURD also engaged Ministry of Education and Sports officials as well as officials from the Ministry of Gender, Labor and Social Development and Parliament on the matter of CSE.[67]

Impact

Two years after filing the case, the Ministry developed an age-appropriate, abstinence-based/ sexual risk avoidance, National Sexuality Education Framework, 2018. The case opened up discussions on CSE in Uganda. The case also opened up engagements with various stakeholders, including, the Ministry of Gender, Labour and Social Development, Ministry of Education and Sports, Parliament of Uganda and Ministry of Health. However, there were negative media reports about CSE[68].

4.3 Actions Based on Legal and Policy Frameworks on Termination of Pregnancy

4.3.1 Center for Health, Human Rights and Development, Prof Ben Twinomugisha & Dr. Rose Nakayi v. The Attorney General (Constitutional Petition No. 10 of 2017)

The Context

In Uganda, unsafe abortion is one of the leading drivers of maternal mortality and morbidity. Some women and girls who are suspected to have terminated pregnancy are arrested and or prosecuted by law enforcement officers (HRAPF, 2016). Some health workers have been arrested and prosecuted while providing post abortion care in order to save lives. Yet, the abortion legal regime is restrictive. Induced abortion is criminalized in Uganda under Sections 141 to 143 of the Penal Code Act except for saving the mother's life under Section 224. According to Article 22(2)

67. Interview with Ms. Nakibuuka Noor Musisi, Deputy Executive Director, Programmes, CEHURD.
68. Interview with Ms. Nakibuuka Noor Musisi, Deputy Executive Director, Programmes, CEHURD.

of the 1995 Constitution, no person is allowed to terminate the life of an unborn child, except as may be authorized by law. This provision generated a lot of debate in the Constituent Assembly (CA), which promulgated the Constitution. Because of the controversial nature of abortion, and as a compromise among the delegates, the CA decided to leave the debate to Parliament, which would come up with an elaborate law on termination of pregnancy.

Litigation

Due to the maternal morbidity and mortality arising out of unsafe abortion and the need to clarify on the law in this area, the petitioners decided to test the meaning of Article 22(2) of the Constitution and the attendant role of Parliament in giving effect to it. The petitioners averred that the omission of the state to formulate and pass a law on termination of pregnancy is inconsistent with and in contravention of Articles 22(2) and 79(1) and (2) of the Constitution. The petitioners sought the interpretation of these provisions.

In the petition, the petitioners outlined the views by the CA delegates on termination of the life of an unborn child. These views include the following: that there were religious and moral grounds for the protection of the unborn child; that the doctors in Uganda had been carrying out abortions for therapeutic purposes but had not been doing so under the protection of the law; and that the law at that time did not anticipate technology, which would enable doctors diagnose foetal abnormalities and maternal conditions leading to termination of pregnancy to save the life of the mother. Other views were that women who got pregnant as a consequence of rape or other criminal acts ought to have been authorized to terminate the resultant pregnancy; and that specifying lawful grounds for abortion was not a constitutional matter and the grounds for abortion could better be provided for if the matter went to parliament. The petitioners further contended that the CA resolved to create a framework on termination of pregnancy on which basis Parliament would enact a law to that effect.

The petitioners sought a declaration that the omission of the state to formulate and pass a law regulating termination of pregnancy contravenes Articles 22(2) and 79 of the Constitution. The petitioners also sought an order that the state through the executive and parliament should, within two years, or such reasonable time as the court may deem fit, of passing judgment, formulate and pass a law regulating termination of pregnancy. In addition, the petitioners sought an order that the AG should report to court on the steps taken after every six months or such reasonable time as the court may deem fit.

The AG denied all the averments in the petition and argued that the government has not, by an act or omission, violated any provisions of the Constitution as alleged by the petitioners. Counsel for both the petitioners and the respondent filed written submissions but court has not yet delivered the judgment on the matter.

Advocacy

CEHURD engaged practicing lawyers and law academia in preparation for the case. Because of the controversial nature of abortion rights that may attract negative publicity due to resistance from religious and cultural quarters, CEHURD decided not to involve the media in the whole court process. Counsel for the petitioners were acutely aware of the negative attitude towards abortion rights that may exist among some of the judges. Against this backdrop, in the opening statement, counsel stated:

'Your Lordships … the petitioners in this matter are not promoting nor do they seek to promote termination of pregnancy in Uganda. My Lords, the petitioners are challenging a legal vacuum created by the omission of [the] state to operationalize Article 22(2) that requires the state to enact a law regulating termination of pregnancy in Uganda'.

However, one major omission on the part of CEHURD was failure to put a human face to the petition, that is, by making some of the victims of unsafe abortion, parties to the petition or obtaining affidavits from them. An affidavit from a doctor who was in conflict with the law due to providing post abortion care, was filed but the doctor passed on later on.

Impact

Since the case has not yet been decided and given the silent approach that CEHURD adopted, it may be difficult to gauge the impact of the case at this stage. One thing is, however, clear: whatever decision comes out of court, there is a likelihood of a backlash from the public, especially faith-based organizations who ostensibly seek to protect family values. These organizations' attitude may have been strengthened by the politics in the United States of America where the Supreme Court overruled the case of Roe v Wade (410 U.S. 113 (1973)). In this case, the Supreme Court held that the right to liberty in the Constitution, which protects personal privacy, includes the right to decide whether to continue a pregnancy. Almost 50 years later, in Dobbs v Jackson Women's Health Organization (No. 19-1392, 597 U.S. (2022)), the Supreme Court overturned Roe v Wade and held that there is no constitutional right to abortion. CEHURD should therefore prepare how to handle the consequences of any verdict that may be delivered.

4.3.2 Human Rights Awareness and Promotion Forum Uganda (HRAPF) v. Attorney General, Constitutional Petition No. 25 of 2020

The Context

Induced abortion is criminalized in Uganda (Sections 141-143 of the Penal Code Act) except for the saving of a mother's life (Section 224 of the Penal Code Act). HRAPF conducted a study on the laws criminalizing abortion and interviewed individuals affected by the laws.[69] The study

[69] HRAPF (2016) The Enforcement of Criminal Abortion Laws in Uganda and its Impact on the Human Rights of Women and Health Workers. Kampala: HRAPF.

found egregious violations of the rights of persons who in turn seek unsafe abortions because of fear of being arrested and penalized under the draconian criminal provisions that are routinely enforced by law enforcement agencies in Uganda. It also found that the majority of persons arrested for abortion related crimes are poor women. The police usually extort money from the arrested women and health workers who may be released after paying money. Some of the women are subjected to public humiliation and exposure in the media in the course of arrest and prosecution. Many of the cases taken before the courts for prosecution on abortion related crimes result into convictions. Health workers that are qualified to provide safe abortion and post abortion care services are reluctant to do so due to fear of getting arrested and having their licenses revoked on grounds of professional misconduct. Criminalization of abortion leads many women to resort to unsafe abortions, many of which result into deaths or morbidities.

CEHURD had filed a petition in 2017 seeking a law for termination of pregnancy, which, however, did not challenge the existing criminal laws. HRAPF therefore felt that they would complement the efforts by CEHURD with a petition challenging the criminal laws themselves so as to create space for an enabling law on termination of pregnancy as dictated by Article 22(2) of the Constitution. The main goals of the HRAPF petition were to: have the criminal provisions nullified; bring the violence and violations that follow the enforcement of the law to the attention of the authorities; and to complement the CEHURD petition[70].

Litigation

The petitioner averred that Sections 141, 142, 143 of the Penal Code Act, which criminalize practices relating to abortion are inconsistent with and in contravention of the provisions of the Constitution, that is, freedom from cruel, inhuman and degrading treatment of punishment;[71] right to life[72]; equality and freedom from discrimination;[73] and the right to health[74].

The respondent contended that abortion is criminal in Uganda unless it is done under the law by a licensed and registered physician to save a woman's life or preserve her physical or mental health. The respondent further argued that Uganda is a signatory to the pro-life movement that advocates against abortion save for exceptional circumstances. The respondent also submitted that the foetus, pursuant to Article 22(2) of the Constitution, has a right to life, and the state, including the court, are duty bound to protect such voiceless lives' right to life. A foetus automatically acquires legal personality deserving protection of the law like any other Ugandan. That the unborn child is a distinct and separate individual/person from the woman carrying it. It has rights, including the right to human dignity[75] and the right to life[76]. The respondents also contended that the Ministry of Health is well equipped to handle women that come with complications of abortion. That it is the mandate of the Ministry of Health to save every life regardless of the circumstances

70. Interview with Dr. Adrian Jjuuko, Executive Director, HRAPF.
71. Articles 24 and 44.
72. Article 22(1).
73. Article 21 and 33.
74. Objectives XIV and XX.
75. Article 24.
76. Article 22(2).

the women would find themselves in. Counsel for both the petitioners and the respondent filed written submissions but court has not delivered the ruling on the matter.

Advocacy

HRAPF had legal strategy meetings attended by their partners, including CEHURD, prior to filing the case. HRAPF decided not to publicize the case through the media in light of hostility from opposing forces, especially faith-based organizations. Thus, the proceedings went on largely unnoticed[77].

Impact

Since the case has not yet been decided and given the silent approach that HRAPF adopted, it may be difficult to gauge the impact of the case at this stage. One thing is, however, clear: whatever decision comes out of court, there is a likelihood of a backlash from the opposition, especially faith-based organizations who ostensibly seek to protect family values. The backlash may be augmented by the reversal of Roe v Wade (410 U.S. 113 (1973)), which conferred a right to abortion, by the Supreme Court in Dobbs v Jackson Women's Health Organization (19-1392, U.S. (2022)). Like CEHURD, HRAPF should therefore prepare for how to handle the consequences of any verdict that may be delivered.

4.3.3 Women's Pro Bono Initiative (WPI) and Grace Katana v Attorney General and Mukono District Local Government, Miscellaneous Cause No. 32 of 2021

Context

The Ministry of Health passed Standards and Guidelines on Reducing Maternal Morbidity and Mortality due to Unsafe Abortion, which provided clarity on how a woman may access safe, legal abortion services in Uganda. They also addressed provision of safe and legal abortion and post abortion care services in public health facilities in the country. However, the implementation of the Standards and Guidelines was stayed by the Ministry of Health indefinitely on 7th December 2015. According to Women's Probono Initiative, the stay of the Standards and Guidelines has led to an increase in unsafe abortions especially for survivors of sexual violence[78].

Litigation

The applicants sought from the High Court of Mukono a number of declarations and orders. They asked court to declare that the omission by the respondents to formulate, pass laws, policies and technical guidance on safe and legal abortion for women and girls exposes them to unsafe abortion practices and unqualified abortion service providers, thereby violating their right to access adequate reproductive health services. They also sought a declaration that the stay of the

[77] Interview with Dr. Adrian Jjuuko, Executive Director, HRAPF.
[78] Women's Probono Initiative 'Case Brief on Access to Safe and Legal Abortion Services in Uganda'.

implementation of the Standards and Guidelines for Reducing Maternal Morbidity and Mortality from Unsafe Abortion by the respondents contravenes women's rights to access information and health services; and freedom from discrimination on grounds of sex. Other declarations sought were: that the omission by the respondents to provide scientifically accurate information on access to safe and legal abortion services, subjects women and girls to torture, cruel, inhuman and degrading treatment by unqualified persons, thereby violating their right to human dignity; and that pregnancy resulting from sexual violence may be terminated under the exception provided under Section 224 of the Penal Code Act.

The petitioners prayed for the following orders: an order for the first respondent to reinstate and implement the Standards and Guidelines for Reducing Maternal Morbidity and Mortality from Unsafe Abortion, 2015; and an order that the respondents develop laws and policies to guide the public on lawful termination of pregnancy as provided in the Constitution and in line with international frameworks that Uganda is party to.

In Attorney General v Women's Probono Initiative and 2 Others (Miscellaneous Application No. 123 of 2021), the Attorney General applied for stay of the hearing of the case of WPI and Grace Katana v Attorney General and Mukono District Local Government, Miscellaneous Cause No. 32 of 2021 pending the hearing and disposal of Constitutional Petition No. 10 of 2017 and Constitutional Petition No. 25 of 2020. Although the Women Probono Initiative opposed the application, the High Court of Mukono granted the stay. WPI proceeded to the East African Court of Justice (EACJ)[79] where it challenged the stay of the proceedings in Miscellaneous Cause No. 32 of 2021 by the Mukono High Court and asked the EACJ to quash and set aside the High Court's decision. WPI sought an order for the reinstatement of the Standards and Guidelines that had been withdrawn by the Ministry of Health as illustrated above. In the alternative, WPI prayed for an order to the High Court of Mukono to hear Miscellaneous Cause No. 32 of 2021.

Advocacy

WPI mobilized communities, activists and media to attend court. They were, however, disappointed by the order of stay by the High Court of Mukono. Unlike Constitutional Petition No. 10 of 2017 and Constitutional Petition No. 25 of 2020, Miscellaneous Cause No. 32 of 2021 had human faces, that is, a girl who had undergone unsafe abortion and a community mobilizer, who in the course of her work in the field of sexual and reproductive health and rights, had seen and talked to women and girls who had procured unsafe abortion with some bleeding to death and others sustaining debilitating injuries[80]. Human faces are critical in strategic litigation as they bring the actual suffering of the people before court.

[79] Women's Probono Initiative (WPI) v The Attorney General of the Republic of Uganda (East African Court of Justice, First Instance Division, Reference No. 22 of 2022)

[80] Interview with Ms. Primah Kwagala, Executive Director, The Women's Probono Initiative.

Impact

Since the cases (Miscellaneous Cause No. 32 of 2021 and Reference No. 22 of 2022) have not yet been decided, it may be difficult to gauge the impact of the case at this stage. One thing is, however, clear: whatever decision comes out of court, there is a likelihood of a backlash from the public, especially faith-based organizations who ostensibly seek to protect family values. WPI should therefore prepare to handle the consequences of any verdict that may be delivered.

4.3.4 Federation of Women Lawyers (FIDA-Kenya) and others v Attorney General and Others, Constitutional Petition 266 of 2015 [2019] Eklr

The Context

Maternal Mortality Rate (MMR) in Kenya is 362 deaths per 100,000 live births[81] and, like in Uganda, unsafe abortion is one of the leading causes of maternal mortality and morbidity in Kenya. According to the Centre for Reproductive Rights (CRR), unsafe abortion is responsible for the deaths of about 2,600 women and girls per year, which translates to seven deaths per day.[82] The 2010 Kenyan Constitution guarantees every person the right to life[83] and life begins at conception.[84] According to the Constitution, abortion is illegal in Kenya, 'unless in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law'[85].

Litigation

JMM, died in 2018 at the age of 14 years. In 2014, at the age of 14, she was forced into sexual intercourse by an older man. She realized she was pregnant when she missed her menstrual periods for two months and started feeling nauseous. However, she did not disclose this to anyone for fear of being blamed and rejected by family members. JMM was introduced by an older girl to a 'doctor'. The 'doctor' made JMM lie on a bed, injected it on her thigh and advised her to go and wait for the fetus to be expelled the next day. When the fetus was not expelled, JMM returned to the 'doctor' who inserted a metal-like cold object in her vagina. The 'doctor' asked JMM to go home as the fetus would be expelled by that evening. That evening, she started vomiting and experiencing severe stomach pains accompanied by heavy bleeding. She did not disclose the fact of abortion to her family and simply said that she had a headache. JMM was taken to a dispensary and later Kisii Teaching Hospital, where the doctors confirmed that she had undergone an unsafe abortion. The fetus was removed and she was discharged. Because her kidneys were failing due to heavy bleeding, her mother (PKM) was advised to take her to Tenwek Mission Hospital, a faith-based hospital where she could obtain dialysis. JMM was discharged after seven days, given that the hospital did not have any equipment to carry out kidney dialysis.

81. Ministry of Health (2019) Reducing Maternal Deaths in Kenya. Nairobi: Ministry of Health.
82. CRR, 'Report: Lives at stake as more Kenyan women and girls opt for unsafe abortion despite constitutional protection' https://reproductiverights.org/report-lives-at-stake-as-more-kenyan-women-and-girls-opt-for-unsafe-abortion-despite-constitutional-protections/ (accessed 1 August 2023).
83. Article 26(1).
84. Article 26(2).
85. Article 26(4).

PKM took JMM to Kenyatta hospital where she was immediately admitted for treatment, including dialysis. She was later discharged as an inpatient but she was to continue receiving treatment as an outpatient. The doctors found that JMM had had a septic abortion and hemorrhagic shock and had developed chronic kidney disease. She was referred for follow-up in the renal unit of Kenyatta National Hospital. By the time of her discharge, the hospital bill had risen to 39,500 Kenyan shillings, which PKM was unable to pay. As a result, JMM was detained at the hospital during which period she slept on a mattress spread on the floor due to scarcity of beds. She felt sick again during her period of detention in the hospital. She was taken to the main ward where she was treated for about four days. She was returned to the detention room where she stayed for a period of two weeks until she was released after the hospital waived the bill.

PKM was advised that JMM should undergo dialysis every month at Kenyatta National Hospital renal unit at a cost of 50,000 Kenya shillings, which PKM could not afford. PKM blamed JMM's predicament on the respondents who withdrew the 2012 Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya and the National Training Curriculum for the Management of Unintended, Risky and Unplanned Pregnancies. By a letter dated 3rd December 2013, the third respondent, that is, the Director of Medical Services (DMS), withdrew the 2012 Standards and Guidelines and by a memo dated 24th February 2014, the DMS withdrew the National Training Curriculum. The Memo stated that the DMS had received information that some members of Kenya Obstetrical Gynaecological Society (KOGS) and its stakeholders were training health care workers on safe abortion and use of medacon (a combination of mifepristone and misoprostol) drugs for abortion. PKM alleged that the withdrawal of the guidelines and the training curriculum undermined the right to access to safe legal abortion services, thus leading to women and girls like JMM undergoing unsafe abortion from untrained and unqualified persons such as the 'doctor' who procured her abortion.

The petitioners argued that Article 26(4) of the Constitution permits abortion in certain circumstances. That the DMS's actions of withdrawing the 2012 Standards and Guidelines and the Training Curriculum were unlawful, irrational, and unreasonable. The petitioners also argued that the effect of the withdrawal created an environment where survivors of sexual violence could not access safe and quality services in reality. The petitioners prayed for a declaration that a number of rights had been violated, that is, the right to the highest attainable standard of health; the right to non-discrimination; right to life; right to be free from cruel, inhuman, and degrading treatment; right to freedom and security of the person; right to information; consumer rights; and the right to benefit from scientific progress. The petitioners also sought a declaration that the right to the highest attainable standard of health, including reproductive health care services, protected in Article 43(1)(a) of the Constitution, entitles victims of sexual violence to abortion in situations where, in the opinion of a trained health professional, continuing with the pregnancy would endanger the life or health of the victim as envisaged in Article 26(4) of the Constitution.

In addition, the petitioners prayed for the following orders from court: an order quashing the DMS's letter and Memo for being unlawful, illegal, arbitrary, unconstitutional and thus null and void ab initio; and an order reinstating and disseminating the 2012 Standards and Guidelines in

their original form and permanently prohibiting the Ministry of Health from taking retrogressive measures that undermine access to safe and legal abortion services and post abortion care. The petitioners also prayed for an order restraining the respondents from restricting the training of health professionals, threatening and or intimidating them from obtaining any instructions, teaching, or learning about safe and legal abortion and post abortion care through their professional organizations or training institutions. Furthermore, the petitioners prayed for an order against the respondents to make comprehensive reparations to JMM, including damages for violation of her rights and physical and emotional harm suffered; provide comprehensive free health care services for all the medical needs of JMM that had arisen because of the violations occasioned to her, and undertake measures to guarantee non-repetition.

Recognizing the complex nature of the question of abortion, the court stated:

> We recognize that we are not dealing with an easy matter. We are called upon to pick or make the best out of a bad situation. This is informed by the fact, conceded by all the parties, that there is a great problem arising from pregnancies which lead to unsafe abortions, and often, death of the would-be mothers. The petitioners argue that the solution lies in a situation where the state provides information, standards, and guidelines on access to safe abortion where pregnancy results from sexual violence. The respondents see the problem as being a social problem, which can only be dealt with in the context of family sex education.[86]

The court observed that Article 26 of the Constitution 'was a compromise of the differing views expressed by the various camps'[87]. The court also noted that 'the constitutional provisions with respect to abortion in a situation in which emergency treatment is required, or where the life of the mother is in danger, is not disputable'[88]. The court held that the Constitution permits abortion in situations where a pregnancy, in the opinion of a trained health professional, endangers the life or mental or psychological or physical health of the mother. Albeit the Constitution does not define the term 'health', the court adopted the interpretation in the 2017 Health Act, which, like the World Health Organization (WHO), defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'[89].

The court observed that the use of the term 'trained health professional' in Article 26(4) was a concession due to the dearth of qualified medical doctors in many health facilities in the country. The court also adopted the definition of 'a trained health professional' in Section 6(2) of the Health Act, as 'a health professional with formal medical training at the proficiency level of a medical officer, a nurse, midwife, or a clinical officer who has been educated and trained to proficiency and skills needed to manage pregnancy-related complications in women, and who has a valid license from the recognized regulating authorities to carry out that procedure'.

86. Paragraph 296.
87. Paragraph 299.
88. Paragraph 356.
89. Section 2.

The court stated:

> In our view, therefore, women and girls in Kenya, who find themselves pregnant as a result of sexual violence, have a right, under Kenyan law, to have an abortion performed by a trained health professional, if that health professional forms the opinion that the life or health of the mother is in danger. Health in our view, encompasses both physical and mental health. While Kenya made a reservation to Article 14(2)(c) of the Maputo Protocol, it is instructive that the words of the Article mirror in some respects the words in the Constitution.[90]

The court held that the general rule is that abortion is illegal in Kenya. However, abortion is permissible, if in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law. The court further held that '[i]t is not the cause of the danger that determines whether an abortion is necessary but the effect of the danger. Therefore, if in the opinion of a trained health professional, emergency treatment is necessary or the life or health of a mother is in danger, abortion is permissible. It therefore follows that if a pregnancy results from rape or defilement, and in the opinion of a trained health professional endangers the physical, mental and social well-being of a mother, abortion is permissible'[91].

The court made the following declarations: that the right to the highest attainable standard of health, right to non-discrimination, right to information, consumer rights, and the right to benefit from scientific progress of the 2nd, 3rd and 4th petitioners as women of reproductive age and other women and adolescent girls of reproductive age whose interest they represent were violated and/or threatened by the letter of 3rd December 2013 and the Memo dated 24 February 2014. The court also declared that the Memo violated or threatened the right of health care professionals to information, freedom of expression and association, consumer rights and the right to benefit from scientific progress. The court quashed the letter and Memo on the grounds that they are unlawful, illegal, arbitrary, unconstitutional and thus null and void.

The court also declared that abortion is illegal in Kenya save for the exceptions provided under Article 26(4) of the Constitution. In addition, the court declared that pregnancy resulting from rape and defilement, if in the opinion of a trained health professional poses a danger to the life or the health (physical, mental and social well-being) of the mother, may be terminated under the exceptions provided under Article 26(4) of the Constitution. The court issued an order directing the respondents, jointly and severally, to pay PKM, 3,000,000 Kenya shillings as compensation for the physical, psychological, emotional and mental anguish, stress, pain, suffering and death of JMM occasioned by the respondents' violation of JMM's constitutional rights.

[90] Paragraph 372.
[91] Paragraph 399.

Advocacy

The petitioners were represented by the Center for Reproductive Rights (CRR). Largely because of the intersectionality of the challenges of poverty/class, rural-urban divide, and gender, which are faced by women and girls who undergo unsafe abortion, CRR needed someone that could bring a 'human face' to the petition. When CRR learnt of JMM's story, they talked to her family. JMM was a girl from a poor family that could hardly afford hospital bills. They supported JMM in her kidney dialysis and other treatment. CRR explained to the family that actions of the Minister of withdrawing the Standards and Guidelines had aggravated JMM's situation because had there been access to safe legal abortion services, she wouldn't have suffered the way she did. As a poor rural girl, JMM was found to be timid. CRR decided to bring in her mother, who could ably explain the JMM's story and experience to court.[92]

Civil Society Organizations (CSOs) involved in Sexual and Reproductive Health issues were against litigation on ground that it would disrupt provision of safe abortion services. Because of the ambivalent attitude of the CSOs, CRR decided to bring in two women working on human rights issues in informal settlements in Nairobi, as petitioners. FIDA-Kenya, a national organization engaged in women's human rights, was also brought in as a petitioner. CRR decided to have the online conversation of the case using a small organization called TICAH. CRR also engaged Independent Health Reporters and a few court reporters to bring issues to the mainstream media. CRR were acutely aware that there was a strong opponent – the Catholic Church – which may not be easily beaten on publicity. Thus, they decided not to use placards and demonstrations to publicize the case. There was no campaign outside the court process as such. Due to the stigma associated with abortion, court granted the request of the lawyers to have the names of JMM and her mother concealed[93].

Impact

From a jurisprudential perspective, there are positive developments that accrue from the case. The court clarified that abortion is a fundamental right in Kenya within the limits prescribed by the Constitution. In light of this, the reservation entered by Kenya against Article 14(2)(c) of the Maputo Protocol is trumped by Article 26(4) and thus does not apply. The court was emphatic that survivors of sexual violence are entitled to safe and legal abortion services. The case also laid a strong foundation for the PAK case below. It should, however, be pointed out that the Attorney General appealed and applied for stay of execution of the judgment pending appeal.[94]

4.3.5 PAK & Another v Attorney General and 3 Others, Constitutional Petition E009 OF 2020) 2022] KEHC 262 (KLR)

92. Interview with Martin Onyango of CRR, the lawyer that argued this case.
93. Interview with Martin Onyango of CRR, the lawyer that argued this case.
94. Interview with Martin Onyango of CRR, the lawyer that argued this case.

The context

Building on the gains in Constitutional Petition 266 of 2015 above, CRR decided to challenge the unconstitutionality of sections 154, 159, and 160 of the Penal Code, which criminalize abortion.

Litigation

The first petitioner (PAK), a form two student, became pregnant after sexual intercourse with a fellow student. PAK experienced complications with her pregnancy including severe pain and bleeding. She went to a clinic where she received emergency care from the second petitioner (a health professional) who examined her and found that she had suffered a spontaneous abortion. The second petitioner performed a successful manual vacuum evacuation, after which the petitioner was in a fair general condition. Plain clothed police officers stormed the clinic without notice or permission from the second petitioner. They demanded to be given the petitioner's treatment records and confiscated them from the second petitioner. The police arrested and detained the staff of the clinic. The second petitioner was charged with procuring abortion contrary to Section 158 and supplying drugs to procure abortion contrary to Section 160 of the Penal Code Act.

The petitioners filed the Petition to quash the criminal trial of the petitioners on grounds that Article 26(4) of the Constitution permitted abortion under certain circumstances. It was contended that the actions of the police of subjecting PAK to a forced medical examination violated her human rights to life, privacy, the highest attainable standard of physical and mental health, and freedom from torture, inhuman and degrading treatment. The petitioners prayed that Sections 154, 159 and 160 should be declared unconstitutional. The respondents argued that the intention of Article 26(4) was to make abortion illegal except for the circumstances, where in the opinion of a qualified medical practitioner, the life of the mother is in danger or that there is need for emergency treatment or where permitted by any other written law.

There were three issued before the court: whether Sections 154, 159, and 160 that criminalize abortion were unconstitutional; whether the lack of access to safe abortion services was a violation of the rights to life, privacy, the highest attainable standard of physical and mental health, and freedom from torture, inhuman and degrading treatment. The court stated:

> Access to abortion services is a human right. Under international human rights law, everyone has a right to life, a right to health, and a right to be free from violence, discrimination, and torture or cruel, inhuman and degrading treatment. Forcing someone to carry an unwanted pregnancy to term, or forcing them to seek out an unsafe abortion, is a violation of their human rights, including the rights to privacy and bodily autonomy.[95]

[95] At pp. 17-18.

The court declared Sections 158, 159 and 160 unconstitutional. It also declared that 'the right to abortion is a fundamental right but it cannot be said to be absolute in light of Article 26(4) of the Constitution.[96] The court directed Parliament to enact an abortion law in terms of Article 26(4) to provide for the exceptions outlined in the Constitution. The court declared that 'the medical doctor/trained health professional licensed to practice medicine in Kenya by the relevant authorities exercising his/her skill, expertise with due care and attention, good faith inferred from the diagnosis carried out on examination of a patient shall not be guilty of an offence in the expansive provisions of the Penal Code on procuring abortion'[97]. The court quashed the criminal proceedings against the petitioners.

Advocacy

Because of opposition from religious leaders, especially the Catholic Church, CRR decided not to involve the media and CSOs in the court process. They decided to employ a silent approach and only the lawyers from both sides and the judiciary knew about the case. CRR informed CSOs when the judgment was about to be delivered.[98]

Impact

This was a landmark case where the Kenya High Court affirmed abortion as a fundamental right under the 2010 Constitution and directed Parliament to enact a law to give effect to Article 26(4) of the Constitution. This is an important precedent in the context of Sexual and Reproductive Health and Rights. The court clarified that forcing a woman to undergo unsafe abortion is a gross violation of her rights to privacy and bodily autonomy.

4.4 Challenging Discriminatory Sexual Violence Related Sanctions

4.4.1 Center for Health, Human Rights and Development (CEHURD), Nnamala Mary & Kakeeto Simon V. Attorney General, Constitutional Petition No. 29 of 2018

The Context

There are many cases of sexual violence, including rape and defilement against women and girls in Uganda. According to the UDHS, up to 22% of women aged 15-49 years in the country had experienced some form of sexual violence[99]. Annually, 13% of women aged 15-49 reported experiencing sexual violence. Among women who experience sexual violence, only a minority report to police for fear of stigma in their communities. The Constitution protects women's rights[100], and children's rights[101], which include freedom from sexual violence. The Penal Code Act also crimi-

96. At p. 26.
97. At p. 26.
98. Interview with Counsel Martin Onyango of CRR.
99. UBOS (2016) Uganda Demographic and Health Survey 2016. Kampala: UBOS.
100. Article 33(3).
101. Article 34.

nalizes rape[102] and defilement[103]. However, these criminal provisions do not accord equal justice to the survivors of sexual violence. In spite of the vulnerability of survivors of sexual violence, government does not provide them with support services, including safety, anonymity, shelters, specially trained psychologists, health workers, rehabilitation and counselling. Thus, the goals of the litigation were to: cause the amendment of the Penal Code Act with an aim of harmonizing the penalties for sexual violence offences; and hold government accountable with a view of having it establish shelters to provide psycho-social support to survivors of sexual violence[104].

Litigation

The petitioners alleged that Sections 124, 129(3) and (4) of the Penal Code Act provide discriminatory penalties to forceful or unauthorized carnal knowledge offences, namely, rape, defilement and aggravated defilement, and are inconsistent with and in contravention of Articles 21(1) and (2) of the Constitution. They also alleged that the omission of the government of Uganda to put in place shelters to provide psychosocial support to survivors of sexual violence is inconsistent with and in contravention of Articles 33(2) and 34(7) of the Constitution. The petition was supported by affidavits sworn by among others, survivors of sexual violence. The petitioners sought the following declarations from court: that Sections 124, 129(1), (3), and (4) of the Penal Code Act are inconsistent with and in contravention of Articles 21(1) and (2) of the Constitution; and that the omission of the government to put in place shelters for survivors of sexual violence to receive psychosocial support is inconsistent with and in contravention of Articles 33(2) and 34(7) of the Constitution.

The petitioners also prayed for the following orders: that the government, within two years, or such reasonable time as the court may deem fit, of passing judgment in this case, enact a law with a uniform penalty on sexual violence offences; and that the government, within two years, or such reasonable time as the court may deem fit, of passing the judgment in this case, construct shelters for provision of psychosocial support to survivors of sexual violence. Finally, the petitioners prayed for an order that the respondent should report to the court on the steps taken to implement the above orders after every six months or such other reasonable time, of passing judgment in this case, as the court may deem fit.

The respondent – the Attorney General denied all the averments in the petition and submitted that different sentences for the various categories of offences do not fall within the grounds of discrimination under article 21 of the Constitution. The case is pending ruling by the court.

It should be noted that in Center for Health, Human Rights and Development (CEHURD), Nnamala Mary & Kakeeto Simon V. Attorney General, (Constitutional Application No. 26 of 2018), the applicants sought an order from court to redact the identities of the survivors of sexual violence who had sworn affidavits in support of the petition in order. The applicants were concerned that the witnesses would suffer social stigma associated with sexual violence if their full names were

[102]. Section 123 and 124.
[103]. Section 129.
[104]. Interview with Ms. Nakibuuka Noor Musisi, Deputy Executive Director, Programmes, CEHURD.

disclosed or published in the public domain. The court allowed the application and granted the following orders: the affidavits of the witnesses be sworn in the ordinary way and filed in court; the registrar of the court redacts the names of the deponents with a dark marker and substitute it with the initials of the deponents for copies of the affidavits that will remain on the public court record; and the registrar should avail the members of the panel and counsel for the opposite party with an unredacted copy of the affidavits in question.

Advocacy

CEHURD conducted legal experts' meetings with lawyers to discuss and develop the pleadings, written submissions and generally strategize for the hearing of the case. CEHURD also engaged the media who actively reported on the case both in the print and electronic media.

Impact

Although the court has not yet issued a ruling on the petition, Constitutional Application No. 26 of 2018 has set an important precedent: that in cases involving vulnerable persons, for example, children, survivors of sexual and gender based violence (SGBV), persons with mental disabilities, persons living with HIV, and women involved in abortion related cases, it is possible to apply to court for their names to be redacted and use their initials instead as was done in the Kenyan case of Federation of Women Lawyers (FIDA-Kenya) and others v Attorney General and Others, Constitutional Petition 266 of 2015, which is discussed below.

4.5 Challenging the Obnoxious and Outdated Provisions of the Venereal Diseases Act

4.5.1 Center for Health, Human Rights and Development (CEHURD) v Attorney General, Constitutional Petition No. 8 of 2019

The Context

Uganda was declared a British protectorate in 1894. The British colonial government imposed a number of laws, including the Venereal Diseases Act, 'through the doctrine of legal reception, in which the British legal culture was transferred to Uganda[105]'. Around 1904, venereal diseases (sexually transmitted diseases) were being cited by the colonial administration as a major cause of infertility, morbidity and mortality[106]. These diseases, according to the colonial administrators, had a deleterious impact on population size, which was seen as a threat to development. Thus, there was a need to curb the spread of venereal diseases through public health law. In fact, in addition to the Venereal Diseases Act, the Public Health Act also had a whole PART VIII (Sections

[105] Moses Mulumba et al 'Decolonizing health governance: A Uganda case study on the influence of political history on community participation' (2021) 23 Health and Human Rights Journal 1, pp. 259-271 available at https://www.hhrjournal.org/2021/06/decolonizing-health-governance-a-uganda-case-study-on-the-influence-of-political-history-on-community-participation/ (accessed 24 August 2023).

[106] Maryinez Lyons 'Sexually transmitted diseases in the history of Uganda' (1994) 70 Genitourin Med, pp. 138-145 available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1195212/pdf/genitmed00020-0062.pdf (accessed 20 August 2023).

49-53) on venereal diseases.

The Venereal Diseases Act and the PART VIII of the Public Health Act contained obnoxious provisions that contravened various human rights and freedoms in the context of Sexually Transmitted Diseases, including HIV/AIDS. The provisions include forced medical examination of persons infected with or suspected to be infected with a venereal disease; treatment without informed consent; detention of persons with a venereal disease; and duty to name a contact. These provisions clearly contravene many aspects of the Constitution and the HIV/AIDS Prevention and Control of Act, 2014 and the East African Community HIV/AIDS Prevention and Management Act, 2012.

Litigation

CEHURD alleged that the Venereal Diseases Act is inconsistent with and in contravention of various constitutional rights provisions, including equality and non-discrimination (Article 21), liberty (Article 23), human dignity (Article 24 and 44), privacy (Article 27), fair hearing (Article 28), administrative remedies (Article 42), and the right to health (Article 45, Objectives XIV and XX) of the Constitution. The respondent denied all the allegations in the petition. The hearing of the case was concluded and judgement is awaited.

Advocacy

CEHURD conducted meetings with legal experts to discuss and develop the pleadings, written submissions and generally strategize for the hearing of the case. CEHURD also engaged the media who actively reported on the case both in the print and electronic media[107].

Impact

It is important to point out that the Venereal Diseases Act was repealed by the Public Health (Amendment) Act, 2022, after the filing of Constitutional Petition No. 8 of 2019. Thus, the Constitutional Court will most likely allow the petition. However, this may be viewed as a win for the petitioners, given that the amended law – the Public Health (Amendment) Act, 2022 will have addressed the inconsistencies that the petitioners sought to challenge in the Constitutional Court. In any case, the Constitutional Court judgment will be a good precedent that will contribute to the jurisprudence in the area of health law, and students, scholars and researchers will find it helpful.

[107]. Interview with Ms. Nakibuuka Noor Musisi, Deputy Executive Director, CEHURD.

5. CONCLUSION

CEHURD has done tremendous work in the struggle for realization of RJ by demanding accountability from the state and non-state actors through courts of law and quasi-judicial institutions such as the Uganda Human Rights Commission. CEHURD has employed an incremental approach to litigation, including the use of non-strategic cases for SL. Before instituting cases, CEHURD undertakes evidence-based research and identifies suitable lawyers and experts from other disciplines. CEHURD has crafted appropriate remedies, including structural interdicts and redaction of identities of survivors of sexual violence. On sensitive and emotive issues such as access to safe abortion, CEHURD, HRAPF and CRR have correctly applied silence as a strategy. In some of the cases involving minors and other vulnerable groups, the organizations have brought human faces, that is, those subjects, who for example, suffered sexual and gender-based violence and unsafe abortion, into the petitions.

A word of caution is, however, in order. A focus on litigation in the struggle for realization of RJ is not a panacea to RJ challenges in the country. Litigation may simply 'massage' the structural and systemic causes of denial of critical components of RJ. For example, I have argued elsewhere that the root cause of maternal mortality and morbidity in Uganda is neo-liberalism, whose policies are antithetical to the realization of socio-economic rights generally and human rights in particular[108]. Litigation, which focuses on individual violations is likely to foster individualism and exacerbate inequalities brought about by privatization and commodification of health care policies. Colleen and Gross have argued that health rights litigation may undermine a fair allocation of resources within a health care system and may destabilize the allocation of scarce public resources to the disadvantage of the most vulnerable[109]. Consequently, limited resources may be diverted to those with the means and ability to litigate RJ or those who may be reached by civil society organizations such as CEHURD. What is comforting, however, is that CEHURD employs litigation alongside other advocacy strategies, including, policy engagements, evidence-based advocacy and community mobilization.

6. RECOMMENDATIONS

CEHURD should, where appropriate, craft remedies that require the court to continue monitoring implementation of its decisions[110]. Such remedies allow the court to remain in charge of implementation of its orders. For example, in the Indian case of Peoples' Union of Civil Liberties & Others v Union of India & Others[111], on the right to food, the Supreme Court provided for a long-term follow-up and monitoring of its various orders that were made to redress violations. CEHURD may also pursue contempt of court procedures. For example, in the South African case of Philane

[108]. BK Twinomugisha, (2017) Maternal Health Rights, Politics and the Law. Professorial Inaugural Lecture, Makerere University.
[109]. MF Colleen & Gross, A (2014) 'Litigating the Right to Health: What Can we Learn from a Comparative Law and Health Care Systems Approach?' (2014) 16 Health and Human Rights Journal 2.
[110]. See for example, JS Clarence 'Reflections on Monitoring the Implementation of Court Orders in Class Action Law Suits' (2011) Intellect Dev Disabil 1.
[111]. Petition (Civil) No. 196 of 2001.

Hlophe & Others v City of Johannesburg & Others[112], the court ordered the city authorities to take all necessary steps to provide shelter required within two months, or face being held in contempt of court or pay fines or their officials receive prison sentences.

CEHURD, should, where appropriate, involve 'human faces', that is, victims of human rights violations, in the litigation process, by for example, swearing affidavits in support of relevant pleadings. The involvement of JMM and her mother in the narrative in the FIDA-Kenya case above indeed bolstered the probability of success of the case. CEHURD should always employ a victim-centered approach in SL by ensuring active, genuine and meaningful participation of victims/litigants throughout the litigation process.

The essential ingredients of participation in SL include, informed consent, confidentiality, and regular, clear and transparent communication in a language that the victims in question understand. Informed choices should drive the whole litigation process. CEHURD should, where possible, ensure that victims, for example of sexual and gender-based violence and or unsafe abortion, have access to essential medical and psychosocial services and shelter. For example, in the FIDA-Kenya case above, CRR met JMM's hospital bills for kidney dialysis and other treatment. If a litigant decides to drop out of the litigation process, their choice should be respected.
It should be pointed out that litigation is usually lengthy, onerous and expensive. Given the poverty levels in the country, cases may only be brought by those who can afford the litigation expenses involved or who may be assisted by organizations such as CEHURD. In any case, the majority of the victims and their families may not be aware of their rights and the procedure for claiming them. Thus, it may be necessary, in non-criminal cases, for CEHURD to always encourage the victims and their families to pursue Alternative Dispute Resolution (ADR) mechanisms, including arbitration, conciliation and mediation.

ADR is a structured negotiation process through which parties to a dispute may negotiate their own settlement with the assistance of an intermediary who is a neutral person. Parties, may instead of going to court to resolve their dispute, agree to refer it for ADR. The advantage of ADR is that it saves the parties time and expenses and promotes reconciliation as opposed to litigation, which is adversarial, formal and may involve a substantial amount of legal costs. ADR may even help in clearing the backlog that is faced by courts in Uganda.

It is good that CEHURD and the other parties have settled some of the cases out of court. Thus, CEHURD should continue exploring the inter-party settlement of RJ related disputes before pursuing any litigation. In some of the cases involving health workers in rural areas, CEHURD may encourage victims to file complaints in the Local Council Courts within the limits of the Local Council Courts Act, 2006. In cases involving medical malpractice or negligence, victims may also be encouraged to directly report complaints to the Medical and Dental Practitioners Council.

CEHURD has, like other organizations, where necessary, actively engaged the media to advocate for issues before the courts. The media is a critical tool of advocacy because through media reporting, the public is sensitized about the issues under litigation and it may act as a catalyst

112 Case No. 48102/2012 (2013), South Gauteng High Court, Johannesburg.

for citizens to demand accountability from the state, its organs and agencies. In some instances, however, it may be necessary for CEHURD and other organizations to inform court about the presence of the media in court.

CEHURD should explore SL around other RJ issues such as non-availability and economic inaccessibility of screening, diagnostic and treatment of reproductive cancers, including cervical cancer, ovarian cancer, colon cancer, breast cancer, prostate and penile cancers. Other potential areas for SL include, forced sterilization; side effects of contraceptives; subsidized cost of assisted reproductive technology such as In Vitro Fertilization (IVF); and the fast tracking of universal health insurance in the country.

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