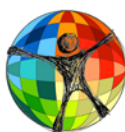


Sexual and Reproductive Health Rights in Uganda: Overcoming Barriers in the Pursuit of Justice, Equity and Prosperity



International Human Rights Internships Program - Working Paper Series



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Abstract

The right to sexual and reproductive health continues to face significant obstacles in Uganda. The first part of this paper explains the development of the right to sexual and reproductive health internationally by examining international law and conventions, such as the World Health Organization Constitution and the International Covenant on Economic, Social and Cultural Rights. In analyzing international legal sources, this paper sheds light on the legality of sexual reproductive health care in Uganda and provides a better understanding of Uganda's national and international obligations in this field. The second part of this paper critically examines the current realities of sexual reproductive health rights in Uganda. It identifies country-specific barriers that impede the realization of these rights and provides insight to some of the challenges facing Ugandans. The third part of This dissertation discusses three specific areas of sexual reproductive health: family planning, parental/antenatal care, and abortion, with a case study that relates to the author's experience working at the Center for Health, Human Rights and Development (CEHURD) in Kampala, Uganda. Finally, this paper concludes with recommendations on how CEHURD and the civil society can work more effectively in realizing change in this field. It concludes by providing insight in what the future might hold for the state of sexual reproductive health rights in Uganda.

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1. Introduction

The right to health is an important subject around the world as it encompasses many fundamental aspects that directly affect the wellbeing of individuals, communities, and nations. Analyzing the multiple facets of health is crucial in determining the bounds of the right to health. The purpose of this paper is to set out the legal contours of the right to health, particularly relating to sexual and reproductive health rights and services in Uganda. Sexual and reproductive health rights is a contested subject in Uganda constrained by numerous physical and societal barriers as well as barriers in governance. In this paper, I argue that Uganda is limited in its ability to attain the highest health standards as set out in various public international law conventions such as the *International Covenant on Economic, Social and Cultural Rights* (ICESCR) and the *African Charter on Human and People's Rights on the Rights of Women in Africa*. The idea for this paper stems from my personal experiences this past summer (2016) as an intern at the Center for Health, Human Rights and Development (CEHURD) in Kampala, Uganda. Throughout my three-month experience at CEHURD, my tasks dealt primarily with the topic of sexual and reproductive health matters in Uganda. My research and involvement at CEHURD revealed an array of human rights related issues grounded in the barriers to health rights and health services.

CEHURD is a leading non-governmental organization in Uganda. They focus their efforts on critical issues relating to health and human rights in East Africa (primarily Uganda) which affect the vulnerable and less-advantaged populations.¹ CEHURD's primary objectives are: (i) to build local, national and regional awareness about health and human rights, and (ii) to promote and advocate for equitable access to health services and goods within Uganda and East Africa. For nearly a decade, this grassroots organization has taken a three-pronged approach in addressing health and human rights issues in Uganda. This consists of, (a) strategic litigation, (b) research, documentation and advocacy, and (c) community empowerment.

Part 1 of this paper sets out the basis for the right to health. By looking broadly at the international legal mechanism and applying them to Uganda more specifically, I will attempt to define the right to health and its limits in Ugandan society. Part 2 will focus on sexual and

¹ Center for Health, Human Rights & Development, "About us", online: <www.cehurd.org/about/>.

reproductive health rights and its barriers. First, I will provide an overview of three key aspects of sexual and reproductive health: (i) family planning, (ii) antenatal health, and (iii) abortion care. From there, I will stem from my experiences working for CEHURD will provide case studies in order to gauge the successes and shortcoming of its programs. This analysis will better inform whether CEHURD's approach has been successful in overcoming some of the barriers to the three important sexual and reproductive health issues. Finally, I will provide recommendations and alternative perspectives on the future of healthcare in Uganda.

2. The Right to Health

The National Economic & Social Rights Initiative defines the right to health as the “right to the highest attainable standard of physical and mental health, which includes access to all medical services, sanitation, adequate food, decent housing, healthy working conditions, and a clean environment”.² The right to health encompasses a wide range of factors, all of which are intended to contribute to the wellbeing, dignity, and prosperity of all people. The right to health is intended to be universally applicable regardless of socio-economic status or geographical location. Theoretically, the right to health guarantees a system of health protection for all. It ensures that everyone has the right to the healthcare they need and to living conditions that enable them to remain healthy. The right to health requires that healthcare be not only available but also accessible and adequate (e.g. in timeliness and in standard).³

The idea of the right to health was first conceptualized and defined by international/intergovernmental organizations in the mid 20th century. In 1946, the World Health Organization (WHO) stressed the importance of the right to health in its Constitution, claiming that it was an essential principle to the happiness, harmonious relations and security of all peoples.⁴ The preamble of the WHO Constitution states:

² National Economic & Social Rights Initiative, “What is the Human Right to Health and Health Care”, online: <www.nesri.org/programs/what-is-the-human-right-to-health-and-health-care>.

³ *Ibid.*

⁴ Constitution of the World Health Organization, 22 July 1946, WHO no 2 at 100 (entered into force 7 April 1948).

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

The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States.

The achievement of any State in the promotion and protection of health is of value to all” (emphasis added).⁵

This statement is significant not only because it stresses the importance of the right to health as a universal right, but also places an obligation on states to ensure the health of its people. Establishing such a broad right to health, however, places the onus on member states to enforce this right on their own initiative (if at all). Because this broad obligation is unenforceable, the WHO has essentially created a right that is only as legitimate as the initiatives of the countries who choose to implement and enforce it.

Two years after the publication of the WHO Constitution, the United Nations General Assembly adopted the Universal Declaration of Human Rights (UDHR). The year-and-a-half-long drafting process united eighteen representatives from around the world with a variety of legal and cultural backgrounds.⁶ Among the many universal rights established in this declaration were the rights to health and security enshrined in Article 25(1):

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.⁷

Article 25(1) contributed to the development of the right to health by recognizing a broader right to general wellbeing that, at first glance, would not necessarily fall within the right to health category. In doing so, the UDHR recognized that factors such as clothing and housing are underlying determinants of health and without them health is inevitably negatively affected. Much like the Convention of the WHO however, the broad scope of the right to health as

⁵ *Ibid.*

⁶ Johannes Morsink, *The Universal Declaration of Human Rights: Origins, Drafting, and Intent* (Philadelphia, University of Pennsylvania Press, 1999) at 4.

⁷ *Universal Declaration of Human Rights*, 10 December 1948.

outlined in the UDHR is largely unenforceable because it places the onus on signatory countries to protect their citizens' rights. While the UDHR has undoubtedly enhanced the awareness and understanding of human rights around the world, its purpose was to establish a set of guidelines rather than a set of strict authoritative rules.

On the same day that the UDHR was adopted, the United Nations General Assembly mandated the creation of a legally binding covenant on human rights. Over the course of sixty years, there have been nine international human rights instruments published, all of which are intended to be binding once they are adopted by states.⁸ One of these covenants is the *International Covenant on Economic, Social and Cultural Rights* (ICESCR). The ICESCR, which has been ratified by most nations, contains a provision that specifically “recognize[s] the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.⁹ The ICESCR was the first international covenant that sought the promotion of health rights, in order to ensure a minimum standard of well-being for all.

Article 12 of the ICESCR charges the states who have ratified the ICESCR with an obligation to adhere to this statement. However, for developing countries such as Uganda, country-specific circumstances often lead to very different interpretations of international agreements and protocols. Indeed, this is sometimes recognized within the international agreements themselves; for example, Article 2(3) of the ICESCR states that “[d]eveloping countries, with due regard to human rights and their national economy, may determine to what extent they would guarantee the economic rights recognized in the present Covenant to non-nationals”.¹⁰ Thus, Article 2(3) absolves the Covenant’s legally binding effect on developing countries, thereby alleviating much of the responsibility placed on states in ensuring that non-citizen’s rights are recognized and respected. Much like how previous international agreements, such as the WHO Constitution and the UDHR, are unenforceable due to the wide breadth of their enshrined rights, the ICESCR proves to be equally unenforceable due to this limitation

⁸ Office of the United Nations High Commissioner for Human Rights, “Uganda and the United Nations Human Rights Mechanisms”, online: <www.ohchr.org/Documents/Countries/PublicationUgandaUNHRMechanisms.pdf>.

⁹ *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976) [ICESCR].

¹⁰ *Ibid.*

clause set out in Article 2(3). While Article 2(3) of the ICESCR gives developing countries some flexibility in guaranteeing that the economic rights of non-nationals' rights are met, the ICESCR also stresses that States have a "core minimum obligation to ensure the satisfaction of minimum essential levels of each of the rights under the covenant".¹¹

These "minimum essential levels" pertaining to the right to health include:

- the provision of essential drugs;
- equitable distribution of all health facilities, goods and services; and
- the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups.¹²

The ICESCR recognizes the economic position of developing countries that may prevent them from meeting certain economic rights requirements. However, the ICESCR still requires that all countries, regardless of their development status, satisfy the minimum right to health requirement. In countries such as Uganda, where the life expectancy is among the lowest in the world –at 56 years old– there is an obvious gap between what has been ratified and the realities people face on the ground.¹³

2.1 The Right to Health in Uganda

The Constitution of Uganda ("the Constitution") lacks an explicit provision on the right to health.¹⁴ While the right has yet to be *legally* protected, it has been recognized in governmental policy documents. For example, both Objective XIV(b) and Objective XX of the *National Objectives and Directive Principles of State Policy* outlines the State of Uganda's commitments and obligations to ensure access to health services for its citizens.¹⁵ Thus, in alignment with

¹¹ Office of the United Nations High Commissioner for Human Rights, "Fact Sheet No. 31: The right to Health", online: <www.ohchr.org/Documents/Publications/Factsheet31.pdf>.

¹² *Ibid.*

¹³ WHO Statistical Information System, *World Health Statistics 2010*, 2010.

¹⁴ *Constitution of the Republic of Uganda (Amendment) Act*, 2005 (Uganda).

¹⁵ *Ibid.*

international agreements and protocols, the Ugandan government has deemed the right to health to be fundamental –even though the right to health is not codified in law.

Further, the Ugandan Constitution does not expressly provide the right to health however, certain articles in the Constitution protect fundamental elements of that right.¹⁶ Article 39 of the Constitution, for example, affirms the right to a clean and healthy environment. Article 39 does not explicitly use the word “health”, however, the Courts have referred to Article 39 in discussing the right to health. The notion of a “clean and healthy environment” pursuant to Article 39 has been relied on to ensure the proper upkeep of health facilities.¹⁷

Article 33(3) and 33(5) of the Constitution require the state to “protect women and their rights, taking into account their unique status and natural maternal functions” and states that “laws, cultures, customs or traditions which are against the dignity, welfare or interest of women or which undermine their status, are prohibited by this Constitution”.¹⁸ When read together, Articles 33(3) and 33(5), work to ensure the protection of women’s right to health in Uganda, a right which inevitably encompasses family planning, antenatal, post-natal, and arguably abortion rights of women.

In 2012, CEHURD, alongside other parties, submitted a petition to the Supreme Court of Uganda claiming that the Ugandan government failed to provide the necessary health care services to expectant mothers and as a result, infringed constitutionally guaranteed rights as well the National Objectives and Directive Principles of State Policy found in the Constitution of Uganda. CEHURD raised both Articles 33(3) and 33(5) in its claim stemming from several maternal deaths that were proven to have been easily preventable if the proper health services were available. The Court found that the Ugandan government’s acts and omissions fell under the doctrine of a ‘political question’, therefore they could not find any competent question requiring constitutional interpretation.¹⁹

¹⁶ *Ibid.*

¹⁷ *CEHURD v Attorney General*, [2012] UGCC 4 (CC Uganda) [*Petition 16*]; *CEHURD v Nakaseke District Local Admin*, Civil Suit 112/2012 [*Nakaseke*].

¹⁸ *Supra* note 14.

¹⁹ *P CEHURD v Nakaseke District Local Admin*, Civil Suit 112/2012 [*Nakaseke*].

Various Courts have addressed the right to health and, like the decision in *CEHURD v Attorney General*, they have deflected the right to health to legislators and policy makers. In South Africa, for example, the Constitutional Court ruled that the Constitution places a positive obligation on the State to provide a minimum of socio-economic rights (which includes health care) in order to meet the needs of its people.²⁰ However, the South African Constitutional Court's application was limited and did defer granting such rights to the legislature. The Supreme Court of Canada in *Chaoulli v. Quebec (Attorney General)*,²¹ denied any constitutional right to health care. However, the Supreme Court of Canada did affirm that if the government implements a health care scheme, it must comply within the parameters of Canada's Charter of Rights and Freedoms.²²

CEHURD v Attorney General shows us that the Ugandan Courts are following the trend that the right to health is not a decision for the judiciary, but rather a legislative one, as set out by other Courts from around the world. Notwithstanding this judicial trend, Kenya's Constitution proposes Article 62(1), which entitles every person to the right to health, which including the right to health services and reproductive health care.²³ Although Kenya's Constitution has yet to become law, it marks an interesting development in the right to health. Being a particularly influential nation in East Africa, Kenya might provide guidance to its neighbours through its proposed constitutional protection of health. With Kenya as a potential exception, we see that the Courts generally face constraints in their imposition to a right to health. Various Courts from around the world must turn to legislature, policy, and governance structures to respond to issues regarding the right to health.

²⁰ *South Africa v Grootboom*, [2000] ZACC 19 (S Afr CC) [*Grootboom*]; *Soobramoney v. Minister of Health (KwaZulu-Natal)*, [1997] ZACC 17 (S Afr CC) [*Soobramoney*].

²¹ *Chaoulli v Quebec (Attorney General)*, [2005] 1 SCR 791, 2005 SCC 35 (CanLII); Sylvia A Law, "A Right to Health Care that Cannot Be Taken Away: The Lessons of Twenty-Five Years of Health Advocacy" (1993) 61 *Tennessee Law Review* 771 at 778.

²² *Ibid.*

²³ *Supra* note 14.

3. Sexual and Reproductive Health Rights

The United Nations Population Fund (UNFPA) defines good sexual and reproductive health as “a state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so”.²⁴ Sexual and reproductive health is an essential part of the universal right to health and to the highest attainable standard of living, which are enshrined in Article 25 of the UDHR as well as other international human rights conventions, constitutions, and declarations.²⁵

Both the Committee on Economic, Social and Cultural Rights and the Committee on the Elimination of Discrimination against Women have stated that women’s right to health includes sexual and reproductive health. Thus, they place an obligation on states to respect, protect and ensure women’s sexual and reproductive health rights.²⁶

Although sexual and reproductive health rights and services affect men and women alike, it is an especially fundamental aspect of a women’s right to health. The focus of sexual and reproductive health is on women, however, men’s roles as fathers and husbands make them key stakeholders in attaining and maintaining healthy populations.²⁷ The focus of this section, however will center on issues women face regarding sexual and reproductive health. There are three main areas that most affect the realization of women and girls’ sexual and reproductive rights: (i) family planning services, (ii) antenatal health services, and (iii) abortion services rights.

²⁴ United Nations Population Fund, “Sexual & Reproductive Health”, online: <www.unfpa.org/sexual-reproductive-health>.

²⁵ Amnesty International, “Sexual and Reproductive Health Rights Fact Sheet”, online: <www.amnestyusa.org/pdfs/SexualReproductiveRightsFactSheet.pdf>.

²⁶ Office of the High Commissioner for Human Rights, Paul Hunt, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, UN Doc A/61/338, 13 September 2006.

²⁷ Adam Sonfield, “Looking at Men’s Sexual and Reproductive Health Needs” (2002) 5:2 *The Guttmacher Report on Public Policy* 7.

3.1 *Sexual and Reproductive Health Rights in Uganda*

Maternal health rights have a significant impact on saving lives and ensuring healthy communities. In Uganda, sexual and reproductive health rights pose a major challenge for women and their families. According to the WHO, roughly five mothers die out of every 100 live births.²⁸ This is a stark contrast from Canada where the number is at roughly .28 per 100 live births, about 18 times less.²⁹

In 2001, the government of Uganda published The National Policy Guidelines and Service Standards for Reproductive Health Services where they introduced the *Safe Motherhood Program* in order to address the persisting sexual and reproductive health issues. The *Safe Motherhood Program* was developed “to ensure that no woman or newborn dies or incurs injuries due to pregnancy and/or childbirth”.³⁰ The Government of Uganda acknowledges that by providing timely, appropriate, and comprehensive care during preconception, pregnancy, and childbirth would help minimize maternal complications and deaths.³¹

The objectives of the *Safe Motherhood Program* are:

- provide guidance to health care providers in the delivery of quality maternal and newborn care services at all levels
- enhance quality of safe motherhood services thereby reducing maternal and newborn morbidity and mortality in the country integrate maternal and newborn care services in the national health system; and
- provide adequate and accurate information education and counseling services.³²

Despite attempts to implement policies such as the *Safe Motherhood Program*, the protection of sexual and reproductive health rights in Uganda has yet to be truly realized and maintained.

²⁸ World Trade Organization, “Accountability for maternal, newborn and child survival: The 2013 Update”, online: <www.who.int/woman_child_accountability/ierg/reports/Countdown_Accountability_2013Report.pdf>.

²⁹ Public Health Agency of Canada, “Maternal Mortality in Canada”, online: <www.med.uottawa.ca/sim/data/assets/documents/Mortality-EN-Final-PDF.pdf>.

³⁰ Reproductive Health Division, Community Health Department, Department of Health, “The National Policy Guidelines and Service Standards for Reproductive Health Services”. May 2001.

³¹ *Ibid.*

³² *Ibid.*

With aspects such as family planning, prenatal health, and abortions carry with them a unique set of barriers, which hinder their accessibility, uptake, and legality.

3.1.1 Barriers

Barriers in the attainment and protection of sexual and reproductive health, which are set out by the ICESCR, can be grouped into three principal categories: societal, physical, and governance. Although different categories present a mix of similar and unique barriers, the aforementioned categories provide some structure in assessing and understanding the issues. By elaborating a little further into each type of barrier, they should not be regarded as exclusive or clear cut because there can be certain degrees of overlap between them.

3.1.1.1 Physical Barriers

Physical barriers to accessing sexual and reproductive health rights and services are tangible and situational in nature. Uganda's physical geography, current economic situation, and allocation of resources provide challenges for providing sexual and reproductive services.

For example: Uganda is undergoing a crisis with staffing in its healthcare sector. The supply of healthcare professionals such as doctors, midwives, and nurses do not meet the needs of the fast growing population. In national healthcare facilities, only half of all posts are filled.³³ A report by the WHO noted that Uganda has one of the lowest government expenditures on health care in Africa, at 26.2% of the country's annual budget.³⁴ Despite significant donor spending on the health care sector over the years, the government has consistently failed to supply the necessary staff, drugs, and equipment countrywide.³⁵ This causes a notable gap in what Ugandans need (and ought to have in accordance with international conventions) and a what there on the ground.

³³ *Supra* note 13.

³⁴ Uganda's government expenditures on health care precedes Sudan at 36.8% and succeeding Togo at 24.9%. See *Supra* note 13.

³⁵ *Supra* note 13.

Although many Ugandans reside in Kampala and other urban centers throughout the country, about 88% of the Ugandan population lives in rural areas.³⁶ With some 70% of Ugandan doctors and 40% of nurses and midwives based in urban areas, the WHO estimates that about half of the population does not have any contact with sufficiently-staffed healthcare facilities. In a 2010 report, the WHO estimates that there is only one doctor and 13 nurses for every 10,000 people in Uganda.³⁷ These physical barriers make it nearly impossible for adequate health care services to be accessed by Ugandans (especially with the majority of the population living outside of urban centres); creating major issues throughout the country.

3.1.1.2 Societal Barriers

Societal barriers to accessing sexual and reproductive health rights and services stem from Uganda's historical, religious, and traditional circumstances. Societal barriers relate to individual and community perceptions, behaviour, and beliefs. Societal barriers are oftentimes based on misinformation as well as the proliferation of stigma stemming from religious and spiritual beliefs and related misconceptions.

For example: the notion of patriarchy within the family and the community mean that women are often valued based on their ability to reproduce. "Early marriage and pregnancy, or repeated pregnancies spaced too closely together, often in an effort to produce male offspring because of the preference for sons, has a devastating impact on women's health with sometimes fatal consequences".³⁸ In Ugandan culture, it is not uncommon for women to be blamed for unwanted pregnancies or infertility, which leads to suffering, abuse, ostracism, and being subject to human rights violations. Societal perceptions have resounding effects throughout communities as there is much resistance to the uptake of certain health care services.³⁹

³⁶ Ann M. Moore, Gabriel Jagwe-Wadda & Akinrinola Bankole, "Men's Attitudes About Abortion in Uganda" (2011) 43:1 Cambridge Journal of Biosocial Science 31 at 36.

³⁷ *Supra* note 30.

³⁸ United Nations Human Rights "Sexual and Reproductive Health and Rights", online: <www.ohchr.org/EN/Issues/Women/WRGS/Pages/HealthRights.aspx>.

³⁹ Such as family planning services, post-abortion care, etc.

3.1.1.3 Barriers in Governance

Barriers in governance regarding the access of sexual and reproductive health rights and services are the result of the acts and omissions of Uganda's decision makers, judicial system, and law enforcement regime. These three institutions are accountable for managing (budgeting and distribution) proper health services throughout the country. However, barriers in governance such as restrictive laws and policies, corruption, and the inability to properly disseminate and uphold laws over their citizens provide significant hindrances in assuring sexual and reproductive health rights.

For example: corruption in Uganda is well-known to be severe, cutting across many sectors, and is frequently debated and discussed in the media. Uganda's challenges pertaining the misallocation of resources, undermines human rights in multiple ways. One of which, is that it shows that the governance cannot be relied upon to protect against the violation of fundamental human rights. Injustices ensue when there is unlawful interference with the procurement or delivery of resources that are meant to be available and/or accessible for citizens.⁴⁰ The governance structure has led to the mismanagement of resources which prevents adequate services to be accessed by citizens in need.

Each of the three barriers to accessing sexual and reproductive health rights and services, in one way or another, is affected by political decisions. The Supreme Court of Uganda emphasized, in the *CEHURD v Attorney General* petition, that the right to health is a political issue. The lack of resources for family planning, antenatal and post-abortion care services create significant barriers in achieving the right to health. In the following three subsections (Family Planning, Antenatal Care, and Post-Abortion Care), I will discuss each sexual and reproductive health topics further and explore the some of the strategies of how CEHURD is working to overcome these barriers.

⁴⁰ "Letting the Big Fish Swim" (21 October 2013), *Human Rights Watch* (website), online: <<http://www.hrw.org/node/119830/section/5>>.

3.2 *Family Planning*

The behaviour towards reproductive matters is known to be shaped by individual characteristics such as attitudes and beliefs, which are conditioned by socioeconomic circumstances. It is less clear whether governments can further influence behavior through the implementation of family planning and re-productive health programs.

The role of family planning programs and their ability to influence individual behaviors remains a point of debate. One can argue that family planning programs can legitimize preferences for smaller families and help meet latent demand for fertility regulation in high-fertility societies. Not surprisingly, contraceptive use is independently and positively correlated with formal education.⁴¹ According to the WHO, Uganda's unmet need for family planning services is 40.6%— the highest country percentage documented. As a point of reference, the WHO indicates that the United States has unmet need of approximately 6%.⁴² With only 23% of Ugandans having access to contraceptives (typically with limited choices in those methods), there are significant barriers to family planning. Uganda has a very high rate of teenage pregnancy— 159 of every 1000 girls (aged 15-19) get pregnant— to put it differently, roughly 16% of teenage girls become pregnant in Uganda.⁴³ To address the burden of unwanted pregnancy, there are two major avenues of appropriate intervention: public education about pregnancy prevention (which includes abstinence and contraceptive use) and contraceptive services.⁴⁴

The community empowerment program at CEHURD aims to work within communities, to build capacity, and educate key stakeholders on rights-based approaches to health. Their strategy focuses on building capacity with key stakeholders, or community health advocates (“CHAs”), within different districts across the country. The community empowerment program chooses strategic areas where health issues are most prevalent. These strategic areas are located predominantly rural communities and within a six-hour vicinity from Kampala. Although

⁴¹ Charles Ketende, Neeru Gupta & Ruth Bessinger, “Facility-Level Reproductive Health Interventions and Contraceptive Use in Uganda” (2003) 29:3 Guttmacher Institute: International Family Planning Perspectives 135.

⁴² *Supra* note 13.

⁴³ *Supra* note 13.

⁴⁴ Guttmacher Institute, “Fact Sheet: Abortion in Uganda”, online: <<http://www.guttmacher.org/pubs/FB-Abortion-in-Uganda.html>> [11 SEP 2016].

maternal health rights (namely family planning services) is their primary focus when visiting communities, the community empowerment program also provides capacity-building training on the right to health involving HIV/AIDS, Tuberculosis, access to emergency medicines, etc.

A secondary objective addressed by the community empowerment program is tackling stigma. By informing communities on the benefits and efficacy of contraception, for example, CEHURD aims to change the perceptions and utilization of health care services within some of the hardest hit areas in Uganda.

3.2.1 Case Study: Community Outreach in the Buikwe

The community empowerment program at CEHURD has chosen the Buikwe District as a strategic region for the delivery of their programs. Buikwe District is located roughly 4 hours east of Kampala and is situated on the coast of Lake Victoria. Many of the communities throughout Buikwe are isolated and reliant on the fishing industry. Hard to reach communities –such as the many of the communities in the Buikwe District– have major obstacles in attaining health care. In remote villages, fishing villages in particular, HIV/AIDS prevalence is three times the national average. “HIV poses a major challenge especially in the hard to access landing sites where access to health care and anti-retroviral drugs are non-existent”.⁴⁵ Because of the high rate of HIV, communities in Buikwe are in particular need of sexual and reproductive health rights promotion and education.

The community empowerment program focuses on training CHAs on issues regarding the right to health, whether it is right to emergency medicines (including anti-retroviral drugs), family planning services or post-abortion care. The program works to inform the public by hosting public events and talk-radio programs as well as visiting schools, community and health centers. Advocating for the right to health at the local level and filing complaints when those services are inadequate is an essential strategy in achieving adequate health care.

⁴⁵ Maurice Ssebisubi, “The Status of Fishing Communities in Buikwe District” (2013) Iceland Development Agency Working Paper No UGA13050013.

The community empowerment program staff consists of lawyers and public health workers who:

- identify key stakeholders in the community
- build/maintain relationships
- facilitate workshops,
- provide training materials,
- provide support and organize community awareness events and campaigns, and
- award monetary incentives to the program stakeholders, such as community organizers and CHAs.

CEHURD focuses on a capacity building strategy that is geared to mobilizing communities towards self-sufficiency in health rights advocacy.

Other objectives of the community empowerment team are to develop strategies that promote sexual and reproductive health literacy where they help train CHAs in assisting community members develop and follow through with family planning strategies. Hosting and co-facilitating open community dialogue along with CHAs builds awareness for the cause. In some cases, CEHURD and CHAs work with church groups, community groups, and schools to access a bigger audience. For example: the community empowerment program and CHAs took an alternative approach to promote their message: they helped organize a local “drama group which is a community-based organization drama group involved in rehabilitating victims of unsafe abortion in Manafwa district”.⁴⁶ The group performed songs and dances related to the prevention of unintended pregnancies amongst the teenage population. Their message also emphasizes family planning and the dangers of unsafe abortion. Stemming from past experiences, they work to reshape the dialogue around issues concerning health rights so that they become more mainstream amongst Ugandans. By working with youth and particularly girls, CEHURD is empowering the group most at risk of experiencing an unwanted pregnancy and having an abortion. This strategic approach has been successful in changing societal perceptions and stigma, which can help mitigate unwanted pregnancies in the long term.

⁴⁶ Center for Health, Human Rights & Development, “Criminalization of Abortion and Access to Post-Abortion Care in Uganda”, (2014) Discussion Paper 4 at p 13.

3.3 *Family Planning*

Over the course of my internship, my colleagues at CEHURD informed me that pregnancy is often the first opportunity for a woman to establish contact with the health system. Antenatal care (ANC) is crucial in mitigating any issues women might face during this delicate period. Uganda has worked considerably to assure antenatal care is provided to bearing women. The WHO reports that in 2010, roughly 94% of pregnant women are accessing at least one visit with a health care provider (usually a midwife or nurse). That percentage drastically decreases for women who receive a second or third check-up throughout their term.⁴⁷

The percentage of births by skilled health personnel has made little improvement over the course of 1990-2010 –from 38% to 42%.⁴⁸ Despite this, other services and important vaccinations have improved considerably. Take for example the issuing of tetanus vaccination at birth, this has doubled over the course of two decades.⁴⁹

Indeed, inequities remain. The lack of skilled health personnel present at the time of birth continue to pose issues throughout Uganda as women in rural parts of the country are roughly two times more likely to give birth in the absence of a skilled health worker. The inequality is further widened if education is taken into consideration. According to the WHO, the least educated women are 26% less likely to have their birth supervised by a skilled health professional, whereas the highest of educated women are three times more likely to have skilled health professionals present.⁵⁰ These discrepancies between socio-economic classes illustrate the gaps within Ugandan healthcare system.

The deployment of health care staff to rural areas can also present real difficulty. This is in part because there are few economic or career incentives to deploy and retain staff in less favourable –namely rural and remote– regions. Districts that face physical barriers in terms of geography have particularly limited access to resources. This results in health care providers being overworked, underqualified, and inadequately resourced.

⁴⁷ *Supra* note 13.

⁴⁸ *Supra* note 13.

⁴⁹ *Supra* note 13.

⁵⁰ *Supra* note 13.

Uganda's shortcomings in providing equitable services are in breach of not only of international covenants such as the ICESCR, but are also in breach of their own domestic policies. Section 12 of the Ugandan Public Health Act states that "the Minister may make rules for the proper control of clinics or institutions open or kept open by any person for the welfare and care of children or the care of expectant or nursing mothers".⁵¹ The essential services however, are not always made accessible. ANC coverage in Uganda is lower among women who need it the most: those who are poor, less educated, and living in rural areas. Women and family's unable to bear the cost for essential ANC or the expenses associated with ANC such as: prescriptions, transportation, taking time off work, etc. Where user fees are in place, safety nets for the poor do not exist.⁵²

3.3.1 Case Study: Strategic Litigation as a Means of Promoting Human Rights

CEHURD has and continues take different approaches in order to address these shortcomings. They are one of the few organizations in Uganda that take a strategic litigation approach to enable change and "redress systemic problems in Uganda's health system".⁵³ Strategic litigation serves as a tool to not only seek justice, but to shine a light on the injustices that Ugandans face with regard to health and human rights. CEHURD has appeared before Ugandan Courts of all levels to defend health and human rights. For example, in 2011, a group of Ugandan health and human rights advocates (led by CEHURD) initiated a case against the government due to inadequate maternal health services, which ultimately led to the death of many women. Their aim was to hold the government accountable for their violations of the rights to life and health, and to force action to reduce maternal mortality. The Constitutional Court of Uganda was reluctant to establish a right to health and claimed it was a political question and not one for the courts. Despite this ruling, momentum within civil society sprung as a result of this judgment. Since CEHURD's initiation of this petition, more than 35 civil

⁵¹ *Joyce Nakacwa v Attorney General and Others*, [2001] UGCC 1 (CC Uganda) [Petition 2].

⁵² Bbaale Edward, "Factors influencing the utilisation of antenatal care content in Uganda" (2011) 4:9 Australian Medical Journal.

⁵³ Center for Health, Human Rights & Development, "Strategic Litigation", online: <www.kehurd.org/programmes/strategic-litigation/>.

society organizations in Uganda have come together to form a coalition advocating for maternal health.⁵⁴

3.4 *Abortion*

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) notes with concern that maternal mortality rates remain very high, with clandestine abortions being a major contributor.⁵⁵ Unsafe abortion is the third leading cause of maternal mortality in Uganda and contribute to 26% of maternal deaths.⁵⁶

In Uganda, abortion is illegal in Uganda except to save the life of the mother. “Very few abortions are performed legally under this rule. Nevertheless, the practice is quite common: About 300,000 induced abortions occur annually among Ugandan women aged 15–49, a rate of 54 abortions per 1,000 women aged 15–49”.⁵⁷ Because the restrictive criteria in the law, a large proportion of these abortions are carried out clandestinely by unqualified providers and often results in complications including death.

Signs of progress were made when Uganda signed the *African Charter on Human and People’s Rights on the Rights of Women in Africa*, also referred to “as the Maputo Protocol”. The Maputo Protocol guarantees comprehensive rights to women, including the right to control their reproductive health: a) right to control their fertility; b) to decide whether to have children; c) to decide on the number and spacing of their children; d) to obtain adequate, affordable and accessible health services and to access medical abortion in cases of rape, defilement, incest, a threat to the mother’s life.⁵⁸

⁵⁴ *Supra* note 18.

⁵⁵ *Convention on the Elimination of All Forms of Discrimination Against Women*, United Nations, 22 October 2010, CEDAW/C/UGA/CO/7 (entered into force 22 October 2010).

⁵⁶ Center for Health, Human Rights & Development, “A Review of Uganda’s Policy and Legal Framework” (2016).

⁵⁷ *Supra* note 33.

⁵⁸ *African Charter on Human and People’s Rights on the Rights of Women in Africa*, African Union, 11 July 2003, (entered into force in Uganda on July 22 2010).

Uganda ratified this protocol in 2010, however insisted on the reservation of article 14, which focuses on women's right to control their fertility and authorization of abortion in specific circumstances. Article 14 of the Maputo Protocol states:

14) State parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted.

this includes:

- a) Right to control their fertility
- b) Right to decide whether to have children, number of children, and spacing of children
- c) The right to choose any method of contraception
- d) Right to self-protection and to be protected against sexual transmitted infections (including HIV/AIDS)
- e) The right to be informed on one's health status and on the health status of one's partner⁵⁹

Despite high hopes from the international community, the reservation of Article 14 gave the Ugandan government and key political stakeholders an opportunity to issue their stance in opposing the right to abortion. A major contributor to this strong opposition was that Catholic Church in Uganda, which continues to take a very conservative stance towards abortion. The Church outspokenly opposed to Uganda's signing of the Maputo Protocol believing that "[t]he situations of severe distress mentioned by the text of the protocol (rape, incest, sexual assault) cannot create the right to suppress an innocent life".⁶⁰ With approximately 40% of the population being Catholic, the Catholic Church remains a major political force in Uganda. They were not only able to sway the government but public opinion as well.⁶¹ Some have perceived Uganda's reservation to Article 14 as straying away from the social goals of the country and

⁵⁹ *Ibid.*

⁶⁰ Paul Bakyenga, "Concerning the Ratification of the 'Protocol to the African Charter on Human Rights and Peoples' Right: on the Rights of Women in Africa'", L'Osservatore Romano: Weekly Edition in English (8 February 2006), online: <www.ewtn.com/library/BISHOPS/letterbpsuganda.htm>.

⁶¹ *Supra* note 41.

contrary to the spirit of the Maputo Protocol.⁶² As the reservation to Article 14 still remains, so do many of the antiquated laws regarding abortion.

The Constitution of Uganda contains Article 22 (2) that prohibits the deprivation of persons' life, including an unborn child. It also provides that in some circumstances the termination of a pregnancy can be lawful. Article 22 (2) of the Constitution states: "No person has the right to terminate the life of an unborn child except as may be authorised by law".⁶³ A point of tension with this constitutional provision is that Article 22 (2) "except as may be authorized by law" suggests that the constitutional drafters anticipated instances where the termination of a pregnancy might or should be permitted and prescribed.

It can be seen that the constitutional drafters not only anticipated but also placed an obligation on the Parliament to make a law which would provide for instances where the termination of a pregnancy would be permitted –such as rape, incest, or defilement. "The Parliament of Uganda has been vested with the mandate to make laws in Uganda. Article 22 (2) not only anticipated but also placed an obligation on the Parliament to make a law which would provide for instances under which the termination of a pregnancy would be permitted".⁶⁴ It has been over 20 years since the Constitution of Uganda has been enacted yet the Parliament of Uganda is reluctant in establishing lawful exceptions to abortion.

The Penal Code Act (the "Penal Code"), which was enacted in 1950, is the criminal code where offences relating to abortion are found. The Penal Code also includes an exception in the form of a defense against prosecution for an abortion-related offence.⁶⁵ Further, there are three specific sections of the Penal Code (sections 141, 142, and 143) that provide for the offences relating to abortion while another (sections 224) that provides a defense against prosecution for an offence relating to abortion.⁶⁶

⁶² *Supra* note 41.

⁶³ *Supra* note 14.

⁶⁴ Center for Health, Human Rights & Development, "Facing Uganda's Law on Abortion: Experiences from Women & Service Providers" (July 2016). Center for Reproductive Rights, online: <www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Uganda-Abortion-Law-Experiences.pdf>.

⁶⁵ *Ibid.*

⁶⁶ *The Penal Code Act of the Republic of Uganda*, 1950 (Uganda).

Section 141 of the Penal Code states that any person who intends to cause the termination of a pregnancy by “unlawfully administer[ing] to any woman any poison, noxious substance or uses any force of any kind, or any means” can serve up to fourteen years of jail time.⁶⁷ This offence punishes any person, including health service providers, who assist and causes the termination of a pregnancy.

Section 142 asserts that any woman who self-administers “any poison or other noxious thing, or uses any force of any kind, or uses any other means, or permits any such things or means to be administered to or used on her” can face up to seven years in prison.⁶⁸ This section of the Penal Code deprives women of their sexual and reproductive health choices.

Section 143 states that any person who supplies “any thing, knowing that it is intended... to procure the miscarriage of a woman” can face imprisonment for three years.⁶⁹ This offence punishes any person who is aware that the results of their efforts will be used to terminate a pregnancy, including a pharmacist or doctors (western or traditional).⁷⁰

The Penal Code, under section 224, provides for a defense to a person accused of any of the offences stated in sections 141, 142, and 143. Section 224 states that a person is not criminally responsible if they performed “in good faith with reasonable care and skill surgical operation... for the preservation of the mother’s life”.⁷¹ Section 224 goes further that the abortion must also be reasonable given the circumstances.⁷² In reality, abortions that fit within the confines of section 224 of the Penal Code are few and far between.⁷³

With little control over their bodies, women and girls face harsh consequences from these Penal Code sections. The consequences of these laws not only affect the women, but their families and communities. Women play a crucial role in their household and within society. The

⁶⁷ *Ibid.*

⁶⁸ *Ibid.*

⁶⁹ *Ibid.*

⁷⁰ *Supra* note 51.

⁷¹ *Supra* note 53.

⁷² *Supra* note 53.

⁷³ *Supra* note 41.

law, through these provisions, encroach on their reproductive health rights and the wellbeing of their family but also affect others in the community.

“The law, as it is right now, is to discourage abortion and to punish offenders. The problem has always been that it is not clear to the law enforcers how it should be enforced. The boundaries of the law are not clear, so in most cases you find that the health workers are the victims”.⁷⁴

–Kirumba Allan

Legal Advisor, Uganda Private Midwives Association (UPMA)

Despite the strict laws against abortion, there is no provision prohibiting post-abortion care in Uganda. However, this does not mean that health care providers do not face legal challenges when performing post-abortion services. Some health care providers have been tried and sentenced to prison, some have served their sentences to the end, while others have spent days in detention and, in some instances, been released with no charge filed against them.⁷⁵ When presented with a case involving post-abortion care, health care providers in Uganda have the burden of weighing their ethical duty to provide medical assistance with the chance of being arrested for their actions, even if they are legal.

The laws related to post-abortion care are inconsistent and contradictory amongst the various stakeholders in Uganda. For example, members of Parliament in Kampala might believe the law on post-abortion care is one thing, meanwhile the police force in a rural district of the country might believe they are another. The effectiveness of laws is questioned when their enforcement is inconsistent, which leads to major issues within the health care system.

“Health workers have been arrested for providing post abortion care, in other instances girls have been manipulated into accepting conviction without legal representation and in other instances prosecutors have failed to find evidence that implicates the accused and the cases have been dismissed. Unfortunately, by the time the cases are dismissed, the reputation and confidence of the health workers and women involved have been tarnished beyond repair”.⁷⁶

–Malumba Moses,

⁷⁴ *Supra* note 51.

⁷⁵ *Supra* note 55.

⁷⁶ *Supra* note 51.

Executive director of the Center for Health, Human Rights & Development

Research by the Guttmacher Institute states that women fear of being mistreated by health care providers when seeking care for abortion complications.⁷⁷ Another significant barrier to post-abortion health care emerges when women with abortion complications are unaware of their sexual and reproductive health rights regarding post-abortion care. There must be a strong social message conveyed to women—and also to health care providers—that women have the right to post abortion care. If health care providers can be further educated about this, it would hopefully reduce their abusive treatment of women with post-abortion complications.⁷⁸

3.4.1 Case Study: Legal support network coalition

Although post-abortion care in Uganda is decriminalized, the health workers who provide medical services to abortion survivors are often persecuted. To help assure the rights of health care workers, CEHURD has formed the Legal Support Network (LSN) –a coalition of lawyers throughout the country to provide *pro-bono* services to help health workers who require legal assistance.

CEHURD is one of the few organizations in Uganda to take a strategic litigation approach to enable change in the right to health. Through the strategic litigation approach, CEHURD provides legal support to persons whose rights relating to health have been infringed upon. Strategic litigation serves as a tool to not only seek justice but to “redress systemic problems in Uganda’s health system”.⁷⁹ With a unique tool to foster change, CEHURD is well positioned to use a legal approach to help uphold the right to health.

4. Looking to the future

In this final section, I hope to shine a light on what the future might hold for CEHURD in its pursuit of a more equitable and healthy future for Ugandans. I believe that a focus on family planning services is the best avenue for change in the landscape of sexual and reproductive health in Uganda. Uganda has one of the highest birthrates in the world and the

⁷⁷ *Supra* note 41.

⁷⁸ *Supra* note 41.

⁷⁹ *Supra* note 50.

above-mentioned sexual and reproductive health issues (family planning, antenatal care and post-abortion rights) also rise alongside the birthrates.⁸⁰ In this context, sexual and reproductive health issues and birthrates are correlative. One strategy to tackle these issues is to educate Ugandans on family planning options. If family planning services become common knowledge within communities, there would likely be a larger uptake and demand for the Ugandan government to provide those services. A push for a decrease in birthrates would likely result in a decrease in mortality rates and abortion-related issues. Family planning is the first logical step in the direction of a healthy population, and CEHURD is in a good position to contribute to this cause.

Improving and expanding the provision of family planning services will help reduce unintended pregnancies, which is the principal cause of abortions in Uganda. Further, the lack of family planning services is one of the primary reasons of the high national birth rate. CEHURD, through its Research, Documentation and Advocacy program, must keep pushing governments –local and national– to make family planning education and services a priority. CEHURD, along with other members of civil society, should work to press the government to redact its policies and budgets so that they best serve the Ugandan population. According to the Guttmacher Institute, greater investments in family planning will also provide savings for the state: every Ugandan Shilling spent on family planning will save more than five times that in post-abortion care services. “The cost of providing contraception in Uganda for one year has been estimated at around \$22USD per user”, while the costs associated with treating post-abortion complications is upwards of \$130 per case.⁸¹ If CEHURD and other members of the civil society are able to push the government towards policy changes that increase investments in family planning services, benefits will transpire through not only family planning services but maternal health as a whole.

⁸⁰ In Kenya, total 'wanted' fertility was 3.5 in 1998, and 3.6 in 2003; in contrast, the figures for Uganda were 5.6 in 1995 and 5.3 in 2001. This provide further indications that Ugandan women want more children than women in Kenya as the Ugandan ideal family size appears generally to be at least one child more than the Kenya. See John Blacker et al “Fertility in Kenya and Uganda, A comparative study of trends and determinants” (2006) 59:3 Taylor & Francis: Population Studies 355 at 357

⁸¹ *Supra* note 40.

In addition, CEHURD's Strategic Litigation and Community Empowerment programs should continue to address the major factors that lead to issues in family planning, be it societal barriers (miseducation) or physical barriers (access to resources). The Community Empowerment program should work alongside community health advocates (CHAs) and other key stakeholders on a long-term basis in order to minimize educational gaps around family planning. Tackling stigma and changing societal norms is a lengthy process that spans generations. CEHURD should persist in building relationships with key community members who promote – through radio shows, events or op-eds in newspapers – the value and appreciation for family planning services and citizens' right to health. Over the past decade, CEHURD has seen success and built from its shortcomings. As the organization continues to grow, the Community Empowerment program will be able promote the right to health across more districts in Uganda.

CEHURD's niche in civil society is its ability to use law as means to advocate for the right to health. CEHURD has been able to bring forth many cases on issues ranging from access to family planning services and access to emergency medicines, to raising a constitutional reference at the Supreme Court.⁸² Strategic litigation is an excellent tool to ensure Uganda's compliance with its international and regional human rights obligations. By advocating for governmental accountability through court battles, CEHURD can continue to contribute to the reduction of maternal deaths and disabilities caused by unsafe abortion in Uganda. Its continued effort in this realm will help to raise awareness in both Ugandan and international audiences.

As CEHURD continues its battle, it is important to understand the power of dialogue and collaboration. In all three of its programs, CEHURD's work is reliant on others, whether it is working with CHAs in Buikwe or creating a coalition of *pro bono* lawyers to assist in cases with wrongfully convicted health workers. Throughout my time at CEHURD, my colleagues often expressed a sense of value in working alongside such an array of stakeholders and organizations. With this being said, I only witnessed a select few interactions with these stakeholders and organizations. For example, I had privilege of meeting another Canadian law student intern who worked at a Ugandan organization with a similar and overlapping mission to that of CEHURD.

⁸² *Supra* note 16.

Civil society organizations should consistently try and build bridges and develop partnerships within their community, because the whole is greater than the sum of its parts. Rather than working in silos, civil society should focus on their common objectives and the opportunities and changes that can emerge when working together.

In addition, I would recommend that CEHURD work to strengthen its relationships with key, influential organizations in Uganda. Religious organizations, universities, social organizations such as the Rotary Club, and even private enterprise, as they all carry a lot of influence within Ugandan society. Simply creating a dialogue with these organizations would help to overcome some of the barriers to sexual and reproductive health rights. Sensitively describing a woman's perspective on abortion or explaining the discrepancy in health services in rural versus urban settings would help to shed light on these topics and provide a better understanding to those who carry influence in society.

As CEHURD continues to make strides in its fight for health and human rights, there remains much work to be done. Through this internship, I was able to get a first-hand perspective on the issues that plague the prosperity of Ugandan communities, whether it was through meeting victims of health rights violations, conducting comparative research, or editing and drafting promotional materials. This allowed me to better understand just how fundamental health rights and services affect a society and how the important the legislature and the judiciary are in assuring that the right to health is met.

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